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# ***JPRS Report***

# **Epidemiology**

***WORLDWIDE HEALTH***

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# Epidemiology WORLDWIDE HEALTH

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[This EPIDEMIOLOGY report contains only material on worldwide health issues. AIDS and other epidemiology topics will be covered in later issues. Comments and queries regarding this publication may be directed to Roberta, FBIS, P.O. Box 2604, Washington, DC 20013.]

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## ANGOLA

### UNITA Health Services, Policy Described

92WE0677A Luanda TERRA ANGOLANA  
in Portuguese 11 Jul 92 p 8

[Text] Without the Angolan people there would be no Angolan nation, and without health there can be no development, which is what the UNITA [National Union for the Total Independence of Angola] Health Service believes, and what it states, specifically in an April 1992 document written for the purpose of providing information about the enormous efforts these services are making to overcome the shortcomings in the health system, which a minister says is the government's responsibility, but which in reality simply corresponds to the MPLA's [Popular Movement for the Liberation of Angola] concept of health.

From UNITA's point of view, the appropriate health system for the "current phase of development" would be characterized by a hierarchy centralized at the top but with broad decentralization at the base, "providing incentives for creative initiative on the part of its technical cadres."

Thus was created a Ministry of Health and Social Well-Being, centralized at the national level, with general directorates involved in the various areas of health, followed by 18 provincial health directors who coordinate the decentralized structure covering Angola's 18 provinces.

This system combines prevention, curative assistance, and rehabilitation, interconnecting the various structures. It depends, like all structures, on human beings, so the role of training is crucial, from the very base levels to specialization of the current technical cadres.

Specifically, it is intended that this health system cover the rural population and maternal-infant assistance, and as a third priority, undertake a national vaccination program. To this end, the UNITA ministry "has created a network of health establishments that correspond to the strategy formulated for the sector and UNITA's implementation capability."

Thus, the UNITA health services administer 18 central hospitals, so categorized because of the type of services they offer (maternity, minor and major surgery, physical therapy, clinical laboratory analysis, and in certain cases, radiology). The central hospitals are provided with at least 30 health technicians to cover the services that they provide.

They are distributed throughout nine provinces, with Cuando-Cubango the best-covered—having six central hospitals—for the historical reason of its resistance to the Cuban-Soviet yoke.

The regional and sectorial hospitals, according to the level of the structure, offer health services in the areas of

maternity, minor surgery, physical therapy, and medicine, and in some cases clinical laboratory analysis, and are provided with at least 20 health technicians.

UNITA maintains 48 regional and sectorial hospitals. They are distributed throughout 15 provinces, with Huambo Province being the best served, having eight hospitals of this type, followed by Cuando-Cubango, with seven.

All together, the following provinces are provided with this type of hospital—Cabinda, Zaire, Uije, Kuanza Norte, Malanje, Lunda Norte, Kuanza Sul, Benguela, Huambo, Bie, Lunda Sul, Moxico, Huila, Cunene, and Cuando-Cubango.

### The First Level of the Structure

In UNITA's view, the local and pilot hospitals "are the first level of the hospital structures," with a minimum capacity for offering specialized services, but providing, however, the important task of patient triage. They are provided with at least eight health technicians each.

They exist in 11 provinces in the country, being greatest in number in Cuando-Cubango (22) and Huambo (18), but also present in Zaire, Uije, Benguela, Malanje, Kuanza Sul, Huambo, Bie, Moxico, Huila, and Cuando-Cubango.

Finally, there are the clinic posts, "the simplest health facilities, and the simplicity of their structure permits their dispersal throughout the country." Their task is to provide curative assistance and patient triage, with great importance placed on support for maternal-infant care and health education for the populace.

Throughout Angola there are 1,018 clinical posts, distributed throughout all 18 provinces, with the greatest concentration being in Cuando-Cubango (178), Huambo (158), Huila (138), and Bie (136).

UNITA also maintains five sanitariums and four leper colonies. To maintain this entire system, UNITA has created and maintains 19 nursing schools, three laboratory analysis schools, and two public health schools. These schools provide ten basic courses and other specialized courses where most of the 9,918 technical health cadres were trained.

The greatest number of these cadres are assistant nursing technicians (4,392), and nurses (3,389), with an additional 582 paramedics and 352 midwives.

The service representing the maintenance and growth of this entire system, in the view of UNITA, a political force which has as its principal priority the task of formulating a political-military struggle, cannot be underestimated. Unfortunately, the government, instead of recognizing in its blood brothers qualities that only dignify the Angolan people, did everything to ignore this effort and prevent it from being publicized. Even worse,

as is evident, nothing has been done until now to integrate all these initiatives into the national health system.

### **MPLA Sectarian Policy**

In a country such as ours, where the health system is extremely fragile, where simple vaccination campaigns are lacking because of vaccine shortages, or worse, because they disappear in the vortex of the parallel economy, one cannot understand how it is possible for the government and the Health Minister to continue to maintain a sectarian and discriminatory policy in the face of the UNITA structures and cadres.

In an area of such urgent national interest, an area requiring immediate intervention, as the hospital strikes proved, the potential of the two current systems, that of UNITA and that of the government, should have been evident since Bicesse, and the efforts of the two political movements should have been integrated. It is only because of the current minister's lack of vision that this did not occur, because it is not credible, at this point in the constitution of the Angolan Armed Forces, which are comprised of FALA [Armed Forces for the Liberation of Angola] and FAPLA [Popular Armed Forces for the Liberation of Angola], that this not be possible, for the good of the entire country, as well as the health sector. Unfortunately, the Order of Doctors has done nothing to pressure the government in this direction, demonstrating a passivity that cannot be comprehended, despite the informal steps that have been taken toward more incisive activity on the party of the Order.

The health area is not supposed to be one in which one can carry out activities of a strictly political-partisan nature in total impunity. Angolan citizens, who contrary to what some think are more aware of these realities than might be supposed, will not cease reflecting on this issue at election time. At that point, the current health minister will certainly regret his sectarian policy.

But until then, the country and Angolans will have lost time and health, and because of that thousands of Angolans will have died unnecessarily. Since Bicesse, 13 months have been lost that could have been used to advantage had there not been so much sectarianism on the part of the MPLA.

But as is evident, and as the state media itself has shown, behind this sectarianism there are also foreign interests and fabulous riches, the result of activities ranging from the sale of pharmaceuticals, to the sale for profit of nonessential health products.

### **Abortion, Family Planning Statistics Given**

92WE0649A Luanda JORNAL DE ANGOLA  
in Portuguese 1 Aug 92 p 9

[Article by Manuel Feio]

[Text] Of all of the abortions performed in hospital institutions, 85 percent constitute veritable crimes, Dr. Isaias Gaspar, a gynecologist and obstetrician at the Augusto N'Gangula Maternity Hospital, has informed JA [JORNAL DE ANGOLA].

He also emphasized that 10 percent are spontaneous abortions, probably caused by diseases, such as malaria and others, and the remaining 5 percent are pregnancies interrupted for reasons of a clinical nature. There are also women in this situation who become pregnant even though they have been using family-planning methods—in other words, obviously involuntarily. "In these situations, and on the basis of the request of the couples, we interrupt the pregnancies. After all, no one is obliged to have children."

The statistics indicate that curettage was performed on 1,050 women at that hospital in 1991. Of these, 53 were interrupted pregnancies; 105 were due to spontaneous abortions, and 893 procedures were criminal in nature.

During the first half of 1992, the curettage procedure was performed 560 times, 83 of which involved interrupted pregnancies. This expert believes that the higher figure "is because of the larger number of women having recourse to family planning."

The women who turn to abortion, according to Dr. Isaias Gaspar, range in age between 18 and 25. The majority are married.

"In the 5 percent of pregnancies interrupted for clinical reasons, we avoid the serious consequences of abortion," Isaias Gaspar said. He added that the 10 percent of the women who have "spontaneous abortions and reach the hospital in time are also spared serious consequences" because "we can successfully combat infection."

### **Reasons and Consequences**

Apart from reasons of a clinical nature, there are other reasons that lead certain women to seek abortion, whatever the conditions may be.

The conditions of life are deteriorating, and the prospects for the future are not the same for all. Young people of all ages are being seduced in various ways, and they always bear the heavy burden of naivete, on the one hand, while on the other, there are the pressures of sexual desire. Unemployed and worried about saving money in order to survive, young people very often ignore the means available for preventing undesirable pregnancies, thus running all of the risks. "Why bring a human being into the world if you have no way to support it?" they frequently ask.

Clandestine "services" are their preference. They do not care about the cost, which is expensive. But under such circumstances, no supervision is close at hand, and their appeals for help only come when something goes wrong.

On the subject of clandestine abortions, Isaias Gaspar said that the criminal cases—above all the serious ones,

which end in the death of the mother—are referred to the Judicial Police. But, he said regretfully, "The patients will never identify the person who performed the abortion."

Death is the most serious consequence. Added to this are loss of the ability to have another child and other types of complications that permanently damage the health of the woman.

#### Family Planning

"Any of the family-planning methods used in our country, and in the majority of other countries, are 100 percent when both husband and wife take precautions," Isaías Gaspar said. He added that when only the woman uses protective measures, these methods fail between 10 and 15 percent of the time. "These are the cases we see in the hospitals."

He expressed regret about the fact that some husbands do not agree to interruption of a pregnancy even when their wives have become pregnant despite the use of contraceptive measures.

The number of women turning to family-planning methods has been increasing recently. However, this specialist says that the hospital establishments are experiencing some difficulties in this connection. "Currently there is a shortage of contraceptive products, and the institutions lack the specific premises needed for performing abortions," he explained.

He advises young people to limit their sexual relations, if they do not want to have children, and to use contraceptive methods. This is the only way of avoiding abortions, he asserted, concluding that "all young people, regardless of age, can obtain contraceptive materials if they are sexually active. There is no longer any need for parental consent."

#### President Inaugurates Pharmaceuticals Factory

92WE0667A Luanda JORNAL DE ANGOLA  
in Portuguese 14 Aug 92 p 3

[Excerpt] Yesterday [13 August] in the city of Benguela, President Jose Eduardo dos Santos cut the ribbon at a new regional pharmaceuticals factory. The ribbon-cutting ceremony at the factory, which has been operating since February but at only 30 percent of its capacity, is part of the schedule of the visit by Jose Eduardo dos Santos to the province which began on Monday [10 August], within the framework of a journey which he has been undertaking throughout the country. The administrative director of the factory, Jacob Isaac, told ANGOP [Angolan Press Agency] that this factory can produce up to 18 types of medications, but that at this moment it is producing just 14, because the remainder are awaiting tests which are being held up due to the lack of reagents. Jacob Isaac stated that the only existing raw material is what was left in the province for the experimental period. "Up until now, we have not

received any more," he said. He revealed that also due to the lack of adequate equipment, the factory's production is limited to liquid medications such as syrups, serums, and ointments, which are being turned out at a pace that does not exceed 30 percent of the installed capacity. This regional pharmaceuticals factory, which was constructed by the Belgian company Besix, has already made sales to the provinces of Bie and Kwanza-Sul and to the Benguela municipality of Cubal in the amount of 35 million new kwanzas. Its construction, technical outfitting and furnishings cost nearly 1.186 billion new kwanzas. In addition to Angola, the project was financed by Belgium, the African Development Bank (ADB), and the African Development Fund. The factory, which is located in the suburbs of the city of Benguela, employs 98 workers, three of whom are foreigners. [Passage omitted]

#### Conditions in Huila Hospitals Described

92WE0667B Luanda JORNAL DE ANGOLA  
in Portuguese 14 Aug 92 p 11

[Article by Cesar Andre: "Huila: Central Hospital Improves Diet, But in the Sanatorium, Some Are Sleeping on the Floor"]

[Text] The situation of the inpatients with regard to meals at the Dr. Antonio Agostinho Neto Central Hospital in Lubango has shown significant improvement lately, according to statements made to JORNAL DE ANGOLA by its director, Dr. Constantina Furtado.

According to the source, this is due to the joint efforts being made by the structures in commerce and the local government. "There really are some shortcomings. As you know, commerce has been liberalized, and now the problems lie in the lack of business capital. Up until now, health care has been free, and the result is that we are dependent on the General State Budget and certain sponsorships," she said.

The Central Hospital has a ridiculously low budget, because, as the director stated, "this year, we received 120 million new kwanzas, which they reduced to 20 percent in the middle of the year, which is nowhere near enough to feed the inpatients and some of the technicians who work in shifts. The prices of products are going up, and it is not always easy to buy articles wholesale. Sometimes we have to go to the black market. There are days when we buy a sack of sugar for 60,000 new kwanzas, or a can of vegetable oil for 58,000 new kwanzas, which is very bad. There are patients who have to be fed following strict medical instructions."

During the second half of last year, the hospital, which has an inpatient capacity of 322 beds, carried out 9,588 consultations in all specialties (general medicine, orthopedics, surgery, and ophthalmology). Each month, the hospital's emergency ward treats nearly 870 patients, and the annual average of outpatient consultations is 20,000 patients in all specialties.

According to JORNAL DE ANGOLA's source, the death rate at this hospital has not changed much. "For three years, it has held at 10 percent, and we consider that to be very good in comparison to what we have been seeing. For a very long time, health care has been experiencing a number of problems, mainly because of hospital resources and the availability of medication."

#### Splints Replace Casts

The question of medication at this hospital is an "Achilles' heel," because, as the director stated, "we have received medicine from Benguela and Luanda at the level of the Ministry of Health, but in very small quantities which do not always meet our needs. For example, this month, we may get chloroquine, presolina, and anesthetic, but next month, these medications may not arrive. For six months now, we have not gotten any ampicilico (a medication that lowers fever), which is very important in a hospital. Since we do not have them, we have sometimes had to depend on the Canadian project (buying)," Constantina Furtado said.

On the other hand, however, the director of the hospital said that for nearly two years they have not done any elective emergency surgery due to the lack of anesthetic and relaxants. In other cases, she added, "We have a little bit of penicillin, vials of pisonas, but what are we supposed to do when they run out?"

JORNAL DE ANGOLA's source said that another of the difficulties with which the hospital is struggling is plaster of Paris. She stressed: "The city of Lubango is very small, but there have been a lot of accidents. When we try to treat a fracture, we have to fall back on using splints due to the lack of plaster of Paris, which is not advisable," she pointed out.

There are 502 workers employed in that hospital, 27 of whom are doctors, counting Angolans and foreigners. It should be remembered, with regard to the foreign doctors, that there has been a reduction of nearly nine doctors due to the fact that they have finished their service contract, and to date they have not been replaced.

#### Sanatorium

On the other hand, 10 people have died of tuberculosis during the first half of this year in the Sanatorium Hospital of Huila, JORNAL DE ANGOLA has learned from the director of the above-mentioned institution, Dr. Francisca de Carvalho.

The figure is lower in comparison with the number of cases recorded during the same period last year, which was 14. That official pointed to the lack of hygiene, alcohol abuse, and malnutrition as the main causes of this deadly disease.

The Sanatorium Hospital of Huila has a 48-bed capacity and is currently tending to more than 50 inpatients of all ages. It carries out various outpatient consultations, and

Francisca de Carvalho has stressed that "it is really impossible for us to work in this manner with patients sleeping on the floor because we do not have the ability to respond."

According to that official, the hospital urgently needs to be renovated. The building is more than 40 years old and has never had any refurbishing done to it.

The lack of an ambulance, bed clothes, and boots and gloves for the basic workers were pointed out by that official, for whom the lack of a means of transportation limits contacts with the green belt, the mills, and Sonangol [National Angolan Fuel Company].

The Sanatorium Hospital of Huila is also grappling with the lack of medications. According to its director, "If the Provincial Health Board does not monitor the situation in the short run, we will have to discharge our inpatients. It does not do anyone any good for us to have inpatients here when we do not have any medicine, because this harms us. We could also be infected," she said.

It should be recalled that the hospital operates with a staff of 64 workers, two of whom are doctors and 14 of whom are nurses.

#### Agriculture Ministry on Cattle Vaccination

92WE0636B Luanda JORNAL DE ANGOLA  
in Portuguese 4 Aug 92 p 5

[Text] Some 502,820 head of cattle have been vaccinated in Huila Province between February and July of the current year by the Provincial Cattle-Raising Department of the Ministry of Agriculture and Rural Development (Minader), its official, Lutero Campos, told ANGOP [ANGOLAN PRESS AGENCY].

According to the source, an increase of 78,858 cattle vaccinated was recorded during this period in comparison with the same period of the preceding year, an increase that he attributed to the fact that access to areas that were unstable during the war years is now possible.

That official said that his sector is currently struggling with the lack of vaccines and veterinary equipment, such as syringes, needles, and *esotermicas* boxes to preserve the vaccine.

The lack of such materials has affected the vaccination campaign in Gambos, Quipungo, and Quilengues, which are considered to be major producers of cattle in the province, Lutero Campos indicated.

According to that source, most of the cattle that have been vaccinated were suffering from hematic and symptomatic carbuncles as the result of a poorly-timed previous treatment. This does not threaten the species, however.

It is not known how many cattle there are in this region, but there is, nevertheless, an annual plan to vaccinate 700,000 head of cattle, a plan that was worked out based on the numbers presented by the peasants who have shown up at the vaccination stations.

GHANA

**Child Immunization Still Below Targets**

92WE0660A Accra *PEOPLE'S DAILY GRAPHIC*  
in English 07 Jul 92 p 1

[Article by Rosemary Ardayfio: "Only 32% of Children Immunised—Survey"]

[Text] Immunisation against the six childhood killer diseases is still below the expected levels despite efforts to increase the coverage.

A national survey undertaken by the Epidemiology Division of the Ministry of Health (MOH) in March, this year, indicated that only 32 percent of children have been fully immunised under the Expanded Programme on Immunisation (EPI).

Out of this figure, 21 percent were immunised before the age of one and the rest, between one and two years.

Dr. Kofi Ahmed, Head Specialist in charge of the Epidemiology Division, who made this known said a committee was set up by the Secretary for Health in April, this year, to review factors affecting coverage.

The committee was also to review past strategies of the Expanded Programme on Immunisation (EPI) and make recommendations to improve coverage at all levels within the Primary Health Care (PHC) set up.

Dr. Ahmed said the committee identified factors affecting the low coverage as inadequate supply of logistics such as syringes and needles and irregular supplies of vaccine to the peripheral areas.

The change of strategy from the well established routine static and outreach approach to mass campaigns, was also established as a factor External donors who support mass campaigns have not been enthusiastic since the end of 1990. [sentence as published]

Health planners for immunisation activities have also not been making use of private institutions to increase immunisation service while supervision and monitoring have not been effective.

The committee, Dr. Ahmed said, recommended among other things, a combination of the static, outreach and extended outreach and this should be combined with limited mini mass-campaigns at the sub-district levels where necessary.

A certain proportion of the Hospital Fee Fund, the committee also recommended must be released to support PHC activities.

The National level, it was further recommended should set realistic targets for each region. This should be monitored routinely with the view to achieving the overall national objective.

MOZAMBIQUE

**Shortage of Medicines Reaches Crisis Proportions**

92WE0700A Maputo *DOMINGO* in Portuguese  
23 Aug 92 pp 6, 11

[Article by Belmiro Adamugy: "Many Sick People, Few Medicines"]

[Text] His face all crinkled and exhibiting a mask of pain, the man walks with a shaky movement. In the Emergency Section [BS] of the Maputo Central Hospital [HCM] the benches are crammed with people. The man with the shaky movement proceeds to the balcony, purchases a ticket for a thousand meticaís, and is told to wait. There are no places left among the benches. He slowly sits down on the cold floor. Time is passing, night is falling, and the pain is getting worse. Finally a nurse calls out his name; it is his turn.

A short time later, his face showing a certain measure of relief, he proceeds to the local pharmacy where he hands over the prescription. The pharmacist, casting a rapid glance at the prescription, says in an abstract manner, we do not have that medication!

The pain is becoming unbearable and the poor man's only consolation is to see other patients receive the same response. It so happens that he is not the only victim of the acute shortage of medication...

The above-mentioned episode is only a drop of water in the great ocean of problems confronting the people in their quest for medications, principally in the case of ambulatory patients; we were able to verify this in the various hospitals we visited.

Basic medications, such as Aminophyllin, for example, very important for asthmatics, especially at this time of the year, Paracetamol, and others; these are in great demand in hospital pharmacies, giving the impression that we have scarcely reached the tip of the iceberg in this question. And what a question!

In the various hospitals and clinics we visited for the purpose of arranging consultations, the answer we invariably received was that "there was nothing available for distribution, since nothing had yet been received from the National Health Service [SNS]."

This situation is much more serious than any other now being experienced at the HCM, the country's largest facility of that type, capable of accommodating 1,500 bed patients in the various departments of which it is composed.

With an average of 250 cases treated annually by its emergency services, HCM, like other organizations of that type in recent times, was unable to escape the shortage of medications needed by its pharmacies. And if we consider the country's present socioeconomic and sociopolitical conjuncture, further exacerbated by talk of a continuous fratricidal war, it is not difficult to ascertain the possible results of that phenomenon.

### Consumption Very High

In view of the general "panic" being felt by the people, said "panic" being traceable to the shortage of medications, our reporting staff made it a point to seek clarification in a number of places. Some sources were willing to cooperate, others were not.

For example, Antonio Bogalho, HCM's clinical director, was willing to offer a few statements to the weekly publication, *DOMINGO*; according to him, one of the principal causes of the shortage of pharmaceutical products is an increase in the levels of consumption.

"For example, in Maputo, in the 1988 to 1991 interval, there was an increase of more than 50,000 cases treated by our emergency services compared with the years which preceded this period," he said.

"Moreover, improvement in the laboratory techniques, X-ray facilities, and the like, in addition to other HCM specialties, have greatly served to increase the consumption of the medications in question," said our source.

Our interlocutor then went on to say that they receive the medications from MEDIMOC [expansion not given] and at times from other organizations of that category. "Some time ago, we received 600,000 Aminophylline tablets from a nongovernmental organization."

The other cause, equally important, of the interruption in the stocking of medications is the extremely low and irregular production levels obtained by MEDIMOC. "The ideal would be for us to receive supplies every three months, but this possibility has not yet been anticipated and the alternatives leave us in a very poor situation."

Again according to our source, the monopolization of the import, export, and distribution of the medications by MEDIMOC is a subject which needs to be carefully reviewed, for...

"Demonopolization opens the door to greater demand; and if the hospitals had their own administration arrangements, they would be able to research the markets in the quest for better prices and maintain stocks commensurate with the people's requirements," says Antonio Bogalho.

### Regarding Interns Everything Is Under Control

Although for so-called ambulatory patients the problem is extremely serious, the situation of those who are

bedridden is precisely the reverse or, at least, the words of Clinical Director Antonio Bogalho would lead us to think so:

"Among the products which we receive, we have been careful to sort out a large quantity of medications and set them aside for patients who may be seriously ill or even terminal. Obviously, on the national level there may be occasions when there is no longer any stock, but we at least try to keep adequate supplies for those who are extremely ill or confined."

Although we are careful to take the above-mentioned steps, from time to time cases arise involving postoperative infection due to the shortage of antibiotics.

To conclude, our source repeated the need to demonopolize the import, export, and distribution of medications on the part of MEDIMOC, for this will give rise to additional medical institutions in this area, and "at the same time stimulate our work which, in recent times, has gradually increased, especially with the introduction of special clinics.

"It should be noted that some individuals are leaving Swaziland and taking up residence at HCM," he asserted.

### We Are Paying MEDIMOC

Concerning the commercial transactions between the hospitals and MEDIMOC, we raised a few questions with Reinaldo Mabeia, head of HCM's pharmaceutical department.

The first is related to the payment or nonpayment of notes for merchandise received from MEDIMOC. He responded that the pharmaceutical department sends the invoices to the Ministry of Health where an allocation is arranged for payment to MEDIMOC.

"The Ministry of Health contains a pharmaceutical department responsible for invoicing; it is this department which ascertains the quantities and qualities of the products in question, after which the invoicing takes place. This is not very practical; therefore, we have now made a proposal advocating autonomy with regard to the Ministry of Health. Until now no answer has been received," he added.

Again in the same tone, that official showed us the copy of a circular issued by the Ministry of Health suspending the supply of hygienic bandages: "We are curious to see how far our dependence will go; as of now, our women in labor will have to deliver the babies at home.

"The purchasing mechanism to which we are subject is impeding our progress; and the same is true regarding our national industry. I personally think that we could resolve some of the problems we have. At this moment, for example, we have a shortage of ferrous salt, a product which is very important in the case of pregnancies, for it stimulates the production of hemoglobin," he said.

### Pharmaceutical Department

Our reporting staff had a short chat with Elizabeth Albino, head of the Pharmaceutical Department of the Ministry of Health, who in cooperation with Amina Gairote, enlightened us regarding the process used in the acquisition of medications.

"The allocation destined for the pharmaceutical sector has begun to decrease as a result of the situation under way in the country. At this moment, we are working completely from the allocation given us by the Ministry of Finance."

That official went on to say that the Ministry of Finance allocates the money in question to MEDIMOC and MEDIMOC in turn imports the medications and distributes them throughout the country in keeping with the orders on hand.

"It is obvious that the supply is often far from satisfying the requirements."

To our question as to the benefits that MEDIMOC would receive, she asserted "that what we must pay is the remuneration for services offered by that company, for," as I already stated, "the allocation which is used to purchase medications belongs to the Ministry."

As for the dependency which her sector of activity might have toward MEDIMOC, our source stated that in the very near future they would have to work in cooperation with that organization, since the work performed by MEDIMOC should be evaluated, MEDIMOC having vast experience in the field of imports and distribution.

### We Are Producing for the Warehouses

Our country has a medication factory called SIF (Swamo Pharmaceutical Industry), installed a year ago and representing the first undertaking of this kind in the memory of the Mozambican people.

Owned by two citizens of Greek origin, Spiros Vovos and Spiros Petrov, the factory has a daily capability of producing five million tablets, 15,000 tubes of pastes or salves of various kinds, and many thousands of vials. However, that factory unit, which employs 110 workers, is producing less than 15 percent of its potential. Why?

"Because we are unable to keep up with our production," said the owners.

In further reference to the company's situation, Spiros Vovos says that SIF's production is primarily aimed at satisfying the needs of the domestic market, specifically the hospitals and pharmacies. However, since last August they have not sold a single vial of medication to the HCM.

"At this moment it is only Farmac which is purchasing a small quantity of medications; about 10 percent of our sales are taken up by this company which, even in this

instance, is sometimes forced to return the merchandise, not having the funds necessary to pay for it," he adds.

"Other purchasers are private pharmacies and a number of agents authorized by the 'List C,'" he says.

Spiros Petrov, meanwhile, stated that "precisely at this time there are many asthmatics having a hard time due to the shortage of Aminophylline; none of this medication is available at the hospital, but we have tons of the product in our warehouses."

Why is that product not being supplied to the hospitals?

In response to our question, Spiros Vovos said that "MEDIMOC is the firm which monopolizes the import, export, and distribution of medications to our medical units and that MEDIMOC does not have the funds necessary to purchase our products."

They (MEDIMOC) say that they operate only on the basis of donations and, therefore, cannot obtain domestic medications. We are confused: "Could it be that our products do not meet the quality standards, or do we not have the necessary capability?"

The SIF people say that they are not accusing anyone but are of the opinion that the country benefited by the donation may be benefiting by as much as 20 percent of the amount received while the donating country may be receiving 80 percent of that amount. And they ask: "Can it be that the foreign currency cannot buy our products?"

Deploring the fact that in many parts of the country thousands of people are questioning the shortage of medications, they assert that "a number of countries such as Swaziland, Tanzania, and Zaire, have asked us to sell them our products but that when we take the necessary steps to arrange the exports, MEDIMOC says that this can be done only by them through the payment of commissions."

"We prefer to close the factory, for in no way shall we export through MEDIMOC and on top of that pay commissions," says Spiros Vovos, adding that "for four months we have done absolutely nothing; our warehouses are full and, in addition, we are forced to pay monthly wages to the workers."

Producing 25 varieties of medications, (the national formula) calls for two dozen and 40 types, the SIF proprietors maintain that purchases should be limited to what is produced domestically for the sake of greater economy.

Holding MEDIMOC responsible for this anomalous situation, they complain that when competition is held regarding market research, they should also be invited to take part on the basis of equality with the others.

### Dark Future, but...

Producing medications like Piperazin, Chloropamida, Phenolphthalein, Sifazol, multivitamins, Cotrimoxazol,

and others. SIF has plans under way to expand its facilities and import more equipment. In this regard, a parcel of land has already been set aside near the present factory where construction is expected to begin.

Spiros Vovos gives us more details: "In addition to expanding the plant, we expect to open a branch in Beira (the facilities are already being rehabilitated) and a pharmacy. Moreover, we are contacting other countries, particularly those of the PTA (Preferential Trade Area) which might be interested in our products."

Spiros Petrov adds that the factory has already been visited by two delegations from Swaziland who expressed a desire to purchase products from SIF. Consultants from the WHO (World Health Organization) and specialists from Israel have also visited the installations, and plans are under way "to export our production."

"What is deplorable is that there are many people outside of Mozambique who are interested in our products, whereas in Cabo Delgado, for example, the local pharmacy is completely out of medications," says Vovos; he then went on to say, "for a population of 16 million people the pharmacies spread throughout the country are insufficient."

#### **We Are Only Retailers**

To cover the vastness of the Mozambican territory there are 60 pharmacies, distributed as follows: 20 in Maputo, six in Beira, two in Nampula, and one in each of the country's provincial capitals; additional pharmacies are located in Gurue, Mocuba, Angoche, Ilha de Mozambique, and Monapo (a clinical station). Farmac is the organization responsible for keeping an eye on the operation of these sales outlets for pharmaceutical products.

Joaquim Durao, director of Farmac, expressed his willingness to speak about this very sensitive area, that is, the sale of medications; he began by saying that the company he directs obtains the products from the suppliers and distributes them to the pharmacies. Briefly speaking, Farmac is a retail company. Purchasing the products from local suppliers—namely, MEDIMOC and SIF—Farmac sells to the consumers at the actual price, using two procedures: the first is to purchase exact quantities and the second is to engage in warehousing. "In the case of MEDIMOC we do this at our pharmaceutical outlets, one of which is located in Beira and another in Nampula, in addition to the main branch located in Maputo," asserts Joaquim Durao.

As for the type of relationship maintained with Farmac's partners, Durao said that "we have good commercial relations with SIF, absorbing about 10 percent of its production and having no reason to complain. Nor do we have any problems with MEDIMOC. Unfortunately, there is almost a general trend to hold MEDIMOC responsible for the shortage of medications; but I believe that this is the result of the current situation prevailing in the country.

Joaquim Durao called particular attention to those who are responsible for the medication problem in general, asserting that "great care must be taken in handling this type of products, for there are always people acting in bad faith who are capable of endangering the lives of thousands of consumers. Quality control must, therefore, be strictly observed, as well as respect for universal principles," he said.

#### **We Depend Entirely on Donations**

MEDIMOC holds the monopoly on the export, import, and distribution of medications to health units, as well as the raw materials for the chemical industry.

Our reporting staff met at this institution with Estevao Macuacua, head of the administrative and financial division, who, at the time, was handling the position of substitute general manager, and Domingos Gomes, director of foreign trade.

It is known that MEDIMOC is responsible for distributing medications to the hospitals. Concerning the justification of the shortage of basic medications to the market and hospitals, Domingos Gomes said: "It is true that our responsibility guarantees the supply of medications to the National Health Service [SNS], but there are many difficulties, for we are working without any plan. At the beginning of the year we were to receive an allocation enabling us to establish a work base, but this is not occurring."

Continuing his explanation, Domingos Gomes added that, for example, "this year began without any allocation whatever; the institution is dependent on foreign assistance, and this is not normal.

"Our dependence is so great that if no help arrives, we do absolutely nothing. About 99 percent of the funds we use come exclusively from donor countries, and even so, we never know precisely when funds will come and how much," said Gomes.

Intervening in the conversation, Estevao Macuacua told our reporting staff that "it is one thing to have definite figures and work on that basis and another to be dependent. MEDIMOC receives partial payments (when it receives funds) in accordance with its needs and we arrange international competitive meets on market research. These competitive meets last a minimum of 45 days and then another two weeks to analyze the information obtained. Only then are bank credits given for resulting orders. All of this slow process transforms what was emergency products into a matter of greater concern."

In further substantiation of these facts, the MEDIMOC officials said (at the time of the interview) that they were awaiting confirmation of the credits being supplied by the Bank of Mozambique [BM] through a letter sent to that institution and that 78 days had passed

without that credit having been forthcoming; meanwhile, BM had assured MEDIMOC that money was available for the purchase of medications.

Another difficulty they pointed out was the fact that the donor companies required that the purchase of the products be made at the places indicated and at certain specified times; they cited Canada as an example.

"This factor limits us very much; but there are other countries, such as Sweden and Norway, which give us the freedom to purchase wherever we wish in accordance with specific shortages," says Estevao Macuacua.

According to Domingos Gomes, the ideal procedure would be to reposition the stock of medications in accordance with a regular schedule and thus avoid any shortages which might otherwise occur; this procedure would also preclude the need for invoicing products supplied to the SNS.

Another matter which we discussed with the MEDIMOC officials was the existence of a pharmaceutical industry in Mozambique. In this regard, we asked what would be the role of that industry in the present situation, given the monopoly held by MEDIMOC in that sphere.

In response, Domingos Gomes said that if MEDIMOC purchases the products from SIF, it would have to sell them to the hospitals through the SNS, which, at the present time, cannot be done inasmuch as the allocation being allotted to the Ministry of Health is greatly reduced.

"MEDIMOC does not prohibit anyone from selling its products to the hospitals. For example, the hospitals purchase merchandise from Johnson and Johnson without any interference on our part; this means that SIF can very well sell its products to health facilities," said Estevao Macuacua.

With a time elapse of more than five months without holding any international competitive meets, MEDIMOC has made it a point to supply certain medications with labels written in foreign languages, thus violating one of the international principles pertaining to the import of such products. In this connection, they give the following justification:

"Our preference is to purchase products with labels in Portuguese; but at times quantities manufactured by Mozambique are either insufficient or must be substituted by a type which, in principle, have not been contemplated. In order not to lose a worthwhile opportunity, we import the product with a label in another language," explains Domingos Gomes.

Another detail which they were careful to point out concerns the bureaucratic procedures involved in the port transactions, which are quite slow: "Inspection of the containers portside is extremely slow, since we have to wait for the bank to free the documents for certification and this takes about two to three weeks; meanwhile, we have to pay for storing the merchandise."

## NAMIBIA

### South Africans To Design New Hospital in North

92WE0682A Johannesburg *ENGINEERING NEWS in English* 21 Aug 92 p 15

[Text] An international competition for the design of a new hospital for the Finnish Engela mission in the north of Namibia has been won by the CSIR [Council for Scientific and Industrial Research] in collaboration with architects Marais, Pretorius and Wenhold.

The competition, organised by the Finnish and Namibian governments, was for a R30-million replacement and upgrading of the existing Engela mission hospital.

The new hospital will initially have 200 beds with space for upgrading to 350.

The design, which preserves all the trees on the site, caters for theaters, a central sterilising supplies department, outpatients, maternity facilities and staff accommodation.

A community health centre will also be built on the site.

About 40 percent of the hospital's patients come from Angola.

## SOUTH AFRICA

### Drought, Inflation Cause Health Problems

92WE0640B Cape Town *THE ARGUS in English* 3 Aug 92 p 6

[Article by Andrea Weiss, health reporter: "Famine on City's Doorstep as Clinics Battle To Cope"]

[Text] The drought and huge increases in food prices has brought famine to Cape Town's doorstep.

Philani Nutrition Project, set up to help severely malnourished children, has seen a huge increase in numbers this year, according to its medical officer, Dr. Ingrid Le Roux, who has been with the organisation for 14 years.

She said the organisation also had had desperate pleas from the ANC Women's League to start more centres in Khayelitsha's Site B, Macassar, Harare and Brown's Farm.

The organisation is helping 3,500 families at three clinics in Khayelitsha and one in Crossroads and most of the children are referrals from local hospitals.

Dr. Le Roux pointed out there were no other medical facilities for severely malnourished children unless they were desperately ill, in which case they might be admitted to Red Cross Children's Hospital.

Philani offers an integrated service incorporating feeding, medical monitoring of the children, mat weaving for their unemployed mothers and educate for children over three.

Dr. Le Roux, who visits each clinic and checks the children's general health, said some were so severely malnourished that they were only half their normal weight when they first arrived for treatment.

A quarter needed treatment for TB and a further 15 percent had an uncertain TB status. Philani sent all the children to be X-rayed and ensured they had been fully vaccinated.

At the Site B clinic, there were about 700 children attending Philani, 30 on a daily basis because their nutritional status was so poor, she said. Some came from Transkei and were brought to Cape Town by their families because they were ill.

The children, who usually took about two months to reach their normal body weight after arriving at Philani, were followed-up for 18 months. If mothers didn't manage to visit, a Philani worker did home visits to find out why.

Dr. Le Roux said the reason most children were there was because of poverty and not because their mothers did not know how to feed them.

She said that often a crisis precipitated the children's illness, sometimes because they had TB, or because the family was in dire economic straits.

By helping the children regain their normal weight, they were given enough of a boost to keep going. She said 83 percent of the children treated were still well after a year.

Dr. Le Roux complained the situation was exacerbated by fragmented health-care in the townships, with mothers having to visit three separate places for vaccinations, TB X-rays and nutritional help.

Philani had its origins in a Shawco clinic started at the community hall in Crossroads in 1979.

Until earlier this year, it had never received government money, but recently was one of a number of welfare organisations in the Western Cape to qualify for a food aid grant.

Anybody wanting to help the project can call (021) 696-9315 or write to PO Box 36214, Glosderry, 7702. The fund-raising number is 088004460008.

#### **ANC Ignores Abortion, Prostitution Issues**

92WE0674C Johannesburg WORK IN PROGRESS  
in English Sep 92 pp 30-31

[Article by Anne Hilton, member of the ANC's regional health committee: "Back to the Branches—Abortion and 'Prostitution' Get the Cold Shoulder"]

[Text] Within current policy development discussions there are two issues that keep getting nudged aside 'for further discussion. The ANC, in particular, seems loathe to commit itself policy-wise to the issues of abortion and commercial sex work—yet both have enormous implications for women's rights and health policy in a future democratic South Africa, argues Anne Hilton.

The issues of abortion and commercial sex practice (or 'prostitution') have plenty in common besides being considered 'too sensitive' for upfront political discussion. Both deal with gender power relations in society and both are often marginalised because of religious and moral objections.

Yet if women are to become fully and meaningfully emancipated in order to participate in a future democratic South Africa, it is essential that these issues are resolved.

#### **Illegal Abortions Risky**

Between 200,000-300,000 women seek illegal abortions every year at great risk to their health, life and fertility.

Baragwanath Hospital in Soweto admits approximately 15,000 patients a year with infections related to illegal abortions. Of these, three or four women die, unnecessarily. By contrast only one percent of legal abortions become infected.

These figures do not take account of the complications which may result from these infections—like infertility. Most victims of restrictive abortion facilities are oppressed and poor women, inevitably black women in South Africa.

Women seek abortions when their jobs are at stake; when they are financially insecure, and cannot afford the burden of another mouth to feed; when contraception has failed; and when partners desert them or are unwilling to accept the consequences of their sexual activity.

Two positions on abortion can be broadly identified.

One, often referred to as pro-life, assumes the rights of the foetus over the mother and defines life as beginning at conception. This position regards abortion as murder of a living organism and will only condone abortion under very restrictive circumstances, such as danger to the mother's life. Prolifers deny women's rights, undermine the impact of patriarchy and oppression on pregnancy, and hold strong moral and religious opinions on the matter.

Arguments pushing for the availability of abortion, on the other hand, recognise the need for abortion in the face of overwhelming statistics, and take into account patriarchy and women's oppression which often deny women control over their own lives and bodies.

During the recent policy development process of the ANC, both pro-life and pro-choice views were strongly voiced.

Only one ANC region discussed the abortion issue in any depth. The health commission of the PWV [Pretoria-Witwatersrand-Vereeniging] region suggested abortion should be made available, together with pre- and post-abortion counselling and appropriate support systems.

This recommendation was taken to the broader PWV regional conference where it was subjected to considerable debate. There was a strong reaction against the idea, with very clear pro-life sentiments being expressed. In a male dominated audience, the pro-choice position was motivated but outweighed by the more aggressive and emotional arguments against. The meeting acknowledged the importance of the issue, but felt it should be referred back to branches for further discussion.

At the National Policy Conference, there was a similar response. Again unable to reach consensus, the health commission and the ANC Women's League noted the impact of illegal abortions on women's health, and asked conference to refer it back to regions and branches for discussion.

#### **Commercial Sex Workers Isolated**

The issue of commercial sex practice met with a similar response. Also emanating from the PWV region's health commission, the issue was raised in the context of the high risk commercial sex workers and their clients face with regard to their health, particularly in the light of HIV and AIDS.

It was noted that commercial sex workers are an isolated and marginalised group in society. They are subject to many prejudices, and the risks to themselves are compounded by the illegal status of their activities.

It was suggested they be integrated into health and gender initiatives, have access to regular health checks and be encouraged to develop strategies which would empower them to make the kinds of demands on clients which would protect their health—like demanding that clients use condoms. This would protect the lives of the commercial sex workers, their clients and the families of both. This strategy has been very successful in many other countries.

When raised at the PWV regional conference and later at the national policy conference, the issue met with a number of similar responses. Many respondents were unwilling to acknowledge the need for such discussion, and in some cases were even unwilling to acknowledge the practice of commercial sex.

"We don't have such things where I live," was a typical response.

Many delegates seemed to be concerned that the ANC should not be seen to condone the activity: "We simply don't want such things to happen."

Yet commercial sex practice exists—it has always existed (as the world's 'oldest profession'), and as long as society remains male-dominated, it will always continue to exist. It cannot and should not be ignored. Our society has to be willing to engage with ideas which ensure that commercial sex workers, mostly women, cease to be invisible members of society, simply serving the needs of men.

#### **ANC Members Conservative**

Both of these issues were referred back to ANC grassroots structures for further discussion.

What both sets of discussions reveal is the large diversity in understanding and consciousness about these issues. It illustrates how conservative many ANC members are, despite their commitment to the broad political objectives of the organisation. More especially, it shows that the fight for non-sexism and the struggle for women's rights is far from over.

Clearly the strategy for further discussion at branch and regional level is critical, but there is also a great need for the spread of education and information, so people can make informed decisions about topics they 'feel' rather than know about.

People often argue about abortion in a mechanistic way, which undermines the ideological issue of women's rights and focuses the debate on the procedure of abortion. People need to know the facts, need to be informed of the objective realities of abortion and how it affects women's lives.

Effective use of both print and audio-visual media, as well as face-to-face contact, may be necessary to spread information and canvass opinion as widely as possible.

#### **Developing Policy**

To develop a policy on abortion, it is necessary to canvass broad opinion both within the ANC and beyond, in a way that ensures that women, both rural and urban, have access to this process.

Changing the abortion laws requires that a number of issues are resolved. These include legal viability (when does the foetus become a person with rights?), whether abortion should be freely available or restricted but flexible, who should pay and so on.

If abortion laws were made more liberal, women would have the right to choose. This does not force women to have abortions, nor does it infringe on anyone's right to object to having an abortion for religious and moral reasons.

A substantial and constructive effort to tackle the controversial issues of abortion and commercial sex practice is long overdue and needs very serious attention.

The ANC can play a very constructive role if it takes the lead in this. By encouraging discussion amongst its own membership, it will establish the base line for policy within its ranks.

But, above all, these are women's issues and it is the women of this country who should have the final say. It is women, after all, who will one day soon constitute some 50% of the electorate.

## ZIMBABWE

### Intensified Campaign Against Bilharzia Planned

92WE0658A Harare *THE HERALD* in English  
14 Jul 92 p 5

[Text] The first-ever nationwide effort to tackle at grass-roots level the bilharzia parasite, affecting three million Zimbabweans, began in Harare yesterday with a week-long course for 55 environmental health technicians.

Organised jointly by the Blair Research Laboratory, a Government agency set up, among other things, to improve primary health care in rural areas, and the Ministry of Health and Child Welfare's Disease Control Unit, the course is the third phase of a three-tier project to boost the anti-bilharzia National Control Programme.

The first phase of the project involved training of central-based specialists and scientists while the second offered training to middle-level managers at provincial level. Technicians attending the course will learn to analyse specimens for contamination and will be working with clinics, schools and villagers in rural wards.

Opening the course, Ministry of Health and Child Welfare Deputy Secretary, Dr. Sam Tswana, said an estimated three million Zimbabweans were infected with bilharzia. But the figure was likely to be conservative considering that more irrigation schemes were being set up countrywide.

Bilharzia is a disease transmitted to humans by a tropical water-borne flatworm which can also live in a certain water snail. The disease affects the pelvic region of the infected person.

Dr. Tswana said that while dams and irrigation schemes were essential, the consequence of this well-meant development brought with it undesirable side-effects of increased bilharzia transmission. However, the spread of the disease could be controlled if dam construction work incorporated systems that drained away bilharzia-transmitting snails.

The National Control Programme, said Blair director Dr. Stephen Chandiwana, focused on three aspects: the pattern of the disease; options available to combat the menace; and health education.

Meanwhile, a widely-available local plant, endod, or *phytolacca dodecandra*, which kills snails, is poised for incorporation into the control programme following successful pilot tests in Chiweshe, said Dr. Chandiwana.

So successful has been the research that Blair Research Laboratory has been designated an endod research centre in partnership with prestigious research organisations like Canada's International Development Research Centre which gave \$1.5 million to the laboratory for further research.

The Danish Volunteer Service, Danida, gave \$100,000. A local insurance company, Old Mutual, is heavily involved while other research organisations in Europe are keenly interested in the project.

**Detection of Viral Antigen in the Marrow Cells of Epidemic Hemorrhagic Fever Patients by Protein A-Gold Technique**

40091021T Shanghai ZHONGHUA CHUANRANBING ZAZHI [CHINESE JOURNAL OF INFECTIOUS DISEASES] in Chinese Vol 10 No 2, May 92 pp 93-95

[English abstract of article by Cao Tinghua [2580 1694 5478], Wu Zhenou [1566 2182 2962], et al. of the First Affiliated Hospital of Hubei Medical College, Hubei]

[Text] Detection of viral antigen in the marrow cells of epidemic hemorrhagic fever (EHF) patients was performed by protein A-gold technique using electron microscope. Clear specific gold particles were observed. All marrow cells showed some degree of ultrastructure abnormalities such as degeneration and vacuolization. The above results suggested that the marrow cells served as a site of viral replication and accumulation, and thus resulted in deficiency of immune function in EHF patients.

Key words: Epidemic hemorrhagic fever; Marrow cell; Protein A-gold technique

**Clinical and Bacteriological Aspects Associated With Chloramphenicol-Resistant Salmonella Typhi**

40091021S Shanghai ZHONGHUA CHUANRANBING ZAZHI [CHINESE JOURNAL OF INFECTIOUS DISEASES] in Chinese Vol 10 No 2, May 92 pp 80-83

[English abstract of article by Tian Weiquan [3944 4850 6898], Wu Yixian [6762 0076 6343], et al. of the Department of Infectious Disease, Affiliated Hospital of Bangbu Medical College, Anhui]

[Text] Forty-six patients with chloramphenicol-resistant salmonella typhi (CRST) were studied on clinical and bacteriological bases. The principal findings were as follows: 1) Onset of the attack was mostly sudden with chill or rigor. 2) Severe toxemia developed as the disease progressed. 3) Rose spots were more common. 4) Blood eosinophil would disappear in most of the patients. 5) Relapse and recrudescence were common. 6) Complications were often present and severe. 7) The mean period of defervescence was longer after treatment. 8) The bacteriophage of CRST was of M<sub>1</sub> type, in more than 90 percent, of the bacteriophage carried, carrying a transmissible R plasmid. 9) Norfloxacin or ofloxacin was the drug of choice in the treatment of CRST.

Key words: Typhoid fever, Chloramphenicol-resistant salmonella typhi (CRST); Antimicrobial susceptibility test, Bacteriophage; R plasmid

**Changes and Clinical Significance of Plasma  $\beta$ -Endorphin in Patients With Epidemic Hemorrhagic Fever**

40091021R Shanghai ZHONGHUA CHUANRANBING ZAZHI [CHINESE JOURNAL OF INFECTIOUS DISEASES] in Chinese Vol 10 No 2, May 92 pp 76-79

[English abstract of article by Chen Qisheng [7115 0796 4141], Sun Zhijian [1327 1807 1017], et al. of the Department of Infectious Diseases, Nanjing Medical College]

[Text] Plasma  $\beta$ -endorphin-like immunoreactive substance (ir- $\beta$ -EP) was dynamically studied in 28 patients with epidemic hemorrhagic fever (EHF). It was found that the concentrations of plasma ir- $\beta$ -EP during hypotensive stage ( $133.33 \pm 57.74$  ng/L in moderate patients, and  $130.58 \pm 48.58$  ng/L in severe patients) were significantly higher than those of normal subjects ( $33.78 \pm 20.62$  ng/L,  $n = 14$ ). Low dose of dexamethasone brought about marked decrease of plasma ir- $\beta$ -EP (from  $104 \pm 45.96$  ng/L to  $58 \pm 24.88$  ng/L,  $P < 0.01$ ). After intravenous administration of thyrotropin releasing hormone (TRH) (300  $\mu$ g), mean arterial pressure increased by  $1.66 \pm 0.76$  kPa although plasma ir- $\beta$ -EP slightly elevated. These results show that there is relationship between circulatory collapse and elevated plasma ir- $\beta$ -EP in EHF, and low doses of dexamethasone and TRH are helpful to improve circulation.

Key words: Epidemic hemorrhagic fever;  $\beta$ -endorphin; Cortisol; Cardionatrin; Thyrotropin releasing hormone

**A Study on the Interference Between Smooth and Rough Species of Brucella in Mice**

40091021Q Beijing ZHONGHUA LIUXINGBINGXUE ZAZHI [CHINESE JOURNAL OF EPIDEMIOLOGY] in Chinese Vol 13 No 3, Jun 92 pp 143-146

[English abstract of article by Li Lanyu [2621 5695 3768], Shang Duqiu [1424 1795 4428], et al. of the Institute of Epidemiology and Microbiology, Chinese Academy of Preventive Medicine, Beijing]

[Text] Smooth-B. abortus 104M, B. melitensis Rev-1 and B. suis S<sub>2</sub> mixed with rough-B. canis RM6/66 respectively were injected into mice. The results demonstrated that s-species of Brucella suppressed R-species of B. canis RM6/66 in mice. The epidemiological phenomenon that R-species of Brucella were difficultly isolated in focus of s-species should be explained on the bases of the study.

Key words: Brucellosis, Brucella, Interference of antigens

**Multilocus Enzyme Electrophoretic Types of *Neisseria meningitidis* Serogroup B and Their Epidemiologic Significances**

40091021P Beijing ZHONGHUA LIUXINGBINGXUE ZAZHI [CHINESE JOURNAL OF EPIDEMIOLOGY] in Chinese Vol 13 No 3, Jun 92 pp 129-133

[English abstract of article by Li Xinwu [2621 2450 2976], Hu Xujing [5170 4872 2417], et al. of the Institute of Epidemiology and Microbiology, Chinese Academy of Preventive Medicine, Beijing]

[Text] In order to expound the epidemiologic relationship between the strains of *Neisseria meningitidis* serogroup B isolated from patients and carriers, 57 case and 45 carrier isolates were collected in 11 provinces and 2 municipalities of China since the 1970s and their multilocus enzyme electrophoretic types and clonal population structures were studied

by multilocus enzyme electrophoresis. It was primarily found that the above strains could be divided into 69 electrophoretic types (ET) and 13 clones. Among others, the clone I was the most important one, because the clone I represented 63.7 percent of all strains tested and 77.2 percent of the case isolates and its district distributions were quite wide since the 1970s. In addition, it was an obvious tendency that more and more of the case isolates gathered up the clone I since 1984 and the predominant ETs also occurred in the complex ET 1 and ET 24 of the clone I. As compared with the case isolates, the above carrier isolates displayed more heterogenetic types. Only 40 percent of all carrier isolates belonged to the above clone I and predominant ETs.

Key words: *Neisseria meningitidis* serogroup B, Multilocus enzyme electrophoretic types, Clonal population structure

## LAOS

### First Nationwide Primary Health Care Conference Held

*BK2110105292 Vientiane KPL in English 0904 GMT  
21 Oct 92*

[Text] Vientiane, October 21 (KPL)—The first Nationwide Conference on Primary Health Care was opened here on October 20 under the chairmanship of Dr. Thongphan Chanthalanon, deputy minister of public health (MPH).

Also taking part in the conference to last four days are some sixty odd persons from the public health services of all the provinces, the representatives of the primary health care committee of the MPH, the Lao Women's Union, Army Medical Service, the Ministry of Education, the Ministry of Agriculture, hospitals, and schools.

The representatives of the World Health Organization, UNICEF, and NGOs [non-governmental organizations] are also attending the conference.

The aim of the conference is to expand the primary health care network and raise the quality of the service. In this framework, the conference is to assess the primary health care service in the country in the last three years.

The participants, in addition, are to study and improve the primary health care policy so as to make it complete and flexible enough to apply in the concrete reality of different socioeconomic parts of the country.

Primary health care plays a key role in the solution of the health status of the Lao people which would enable the country to reach the goal of the slogan "Health for All by the Year 2000".

**BULGARIA****Ministry of Health Regulations on Immunizations**

92WE0372A Sofia DURZHAVEN VESTNIK  
in Bulgarian No 24, 24 Mar 92 pp 2-5

[Text of two Ministry of Public Health orders, both signed by Minister N. Vasilev]

[Text] Order Rescinding Order No. 13 on the Organization of Labor and the Allocation of Working Time of Public Health Workers, dated 10 July 1984 (Unpublished)

**One paragraph only.** I hereby rescind Order No. 13 on the organization of labor and the allocation of working time of public health workers, dated 10 July 1984.

**Order No. RD-09-110a,  
26 February 1992**

On the basis of Article 18 of the Law on Public Health and the decision of the Public Health Ministry Commission of Serums and Vaccines, and in conformity with the recommendations of the World Health Organization and

with the requirements of the Expanded Immunization Program for Lowering Morbidity from Communicable Diseases and for the Elimination of some of them, as well as for the strengthening of immunization practice in the country, I hereby order, as follows:

1. With effect from 16 March 1992, a new immunization calendar of the Republic of Bulgaria and the appendix thereto shall be introduced in the country.

2. The director of the National Health Information Center shall formulate and introduce by 30 April 1992 program backup of an automated system for the administration of prophylactic immunization, consistent with the requirements of the new immunization calendar of the Republic of Bulgaria.

This order cancels Order No. RD-09-263 of 3 April 1989 (unpublished).

I entrust the implementation of the order to the heads of health care institutions and the directors of KhEI's [hygiene-epidemiological institutes], and the monitoring thereof to the deputy ministry—the Chief State Medical Inspector.

**Immunization Calendar of the Republic of Bulgaria**

Age	Immunization	Vaccine	Mode of Administration
First 24 hours after birth	Hepatitis Type B immunization (first dose)	Recombinant hepatitis B vaccine	Intramuscularly, 0.5 ml
48 hours after birth	Tuberculosis immunization	Tuberculosis vaccine (BCG)	Intracutaneously, 0.1 ml
1 month	Hepatitis B immunization (second dose)	Recombinant hepatitis B vaccine	Intramuscularly, 0.5 ml
2 months	Poliomyelitis (first dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops
	Diphtheria-tetanus-pertussis immunization (first dose)	DTK [difteriya, tetanus i koklyush; hereinafter DTP] vaccine	Subcutaneously, 0.5 ml
3 months	Poliomyelitis immunization (second dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops
	DTP immunization (second dose)	DTP vaccine	Subcutaneously, 0.5 ml
4 months	Poliomyelitis immunization (third dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops
	DTP immunization (third dose)	DTP vaccine	Subcutaneously, 0.5 ml
6 months	Hepatitis Type B immunization (third dose)	Recombinant hepatitis B vaccine	Intramuscularly, 0.5 ml
7-10 months	Checking for sign after BCG immunization; on children with no sign, Mantoux test is made (5 International Units of PPD [purified protein derivative]), and those who are negative are immunized	BCG vaccine	Intracutaneously, 0.1 ml
13 months	Measles-mumps-rubella immunization	Measles-mumps-rubella trivaccine or corresponding monovaccine	Subcutaneously or intramuscularly, 0.5 ml
14 months	First poliomyelitis reimmunization (fourth dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops
22-24 months	Second poliomyelitis reimmunization (fifth dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops

**Immunization Calendar of the Republic of Bulgaria (Continued)**

Age	Immunization	Vaccine	Mode of Administration
Up to 24 months (not earlier than 1 year after third dose)	Second DTP reimmunization (fourth dose)	DTP vaccine	Subcutaneously, 0.5 ml
6-7 (first grade)	Third poliomyelitis reimmunization (sixth dose)	Trivalent live poliomyelitis vaccine (Types I, II, III)	By mouth, 2 drops
	Diphtheria and tetanus reimmunization	DT vaccine	Intramuscularly, 0.5 ml
	Tuberculosis reimmunization (following a negative Mantoux test)	BCG vaccine	Intracutaneously, 0.1 ml
10-11 (fifth grade)	Tuberculosis reimmunization (following a negative Mantoux test)	BCG vaccine	Intracutaneously, 0.1 ml
11-12 (sixth grade)	Measles-mumps-rubella reimmunization	Measles-mumps-rubella trivaccine	Subcutaneously or intramuscularly, 0.5 ml
	Diphtheria-tetanus reimmunization	DT vaccine	Intramuscularly, 0.5 ml
16-17 (10th grade)	Tetanus reimmunization	Tetanus toxoid	Intramuscularly, 0.5 ml
	Tuberculosis reimmunization (following a negative Mantoux test)	BCG vaccine	Intracutaneously, 0.1 ml
From 25 on, every 10 years	Tetanus reimmunization	Tetanus toxoid	Intramuscularly, 0.5 ml

**Appendix**

**Basic Principles, Intervals and Compatibilities in Prophylactic Immunizations**

**I. Basic Principles**

1. Immunizations and reimmunizations shall be performed after examination by a physician.
2. Immunizations and reimmunizations shall be performed throughout the year according to the modes and in the sequence indicated in the immunization calendar. For children who are not immunized (reimmunized) at the appropriate age and are two months' overdue, individual immunizations (reimmunizations) shall be arranged on a priority basis as follows:
  - a) Immunization (reimmunization) against: poliomyelitis; diphtheria, tetanus, and pertussis; measles, mumps, rubella; hepatitis Type B; tuberculosis;
  - b) All immunizations have priority over the various types of reimmunizations.
3. In epidemic situations, by decision of the minister of public health, the following vaccines can be administered at an earlier age: poliomyelitis vaccine immediately after birth (zero dose) and measles vaccine before the age of 12 months. These doses are emergency doses and do not change the applicable immunization scheme envisaged in the calendar.
4. The doses to be administered, the side reactions, and the medical contraindications are given in the instructions for the use of the respective vaccines.
5. For a complete basic immunization, the following are to be taken:

a) Three doses of the following vaccines: DTP, poliomyelitis, and hepatitis B;

b) Two doses of TT [tetanichen toksoid; tetanus toxoid]<sup>1</sup>

6. The vaccines are effective during the indicated period of potency if refrigeration (2 to 8°C) is provided during transport and storage.

7. Freezing of adsorbed vaccines (DTP, DT, TT, and hepatitis B) must not be permitted. On thawing, they are unfit for use.

**II. Intervals and Compatibilities of Immunizations and Reimmunizations**

**1. Intervals between doses of the same vaccine:**

a) Vaccines for which the basic immunization comprises several doses (DTP, DT, TT, poliomyelitis), the minimum interval between individual doses is 30 days; for hepatitis B vaccine, the minimum interval between the first and second dose is 30 days, but between the second and third dose is three to five months;

b) In case of a prolongation of the interval between doses, the next doses are to be administered at the first opportunity, without starting the immunization scheme afresh—that is, without administering additional doses of vaccine;

c) In the absence of stable contraindications, the immunizations against diphtheria, tetanus, and pertussis, poliomyelitis, and hepatitis Type B shall be completed not later than the age of 12 months. After this age, even for children with a strong reaction after the DTP immunization dose, the DT vaccine is to be administered;

d) The DTP vaccine is to be administered for reimmunization before the age of 24 months is reached, but no earlier than one year after completion of the basic immunization;

e) In case of the necessity of two consecutive doses of monovaccines (measles, mumps, rubella) or of a combined vaccine (measles-mumps-rubella), the minimum interval is 30 days. No upper age limit for immunization (reimmunization) with these vaccines is to be observed;

f) The BCG vaccine is to be administered two months after examination for tuberculin sensitivity with the Mantoux test (5 IU of PPD); the vaccine is to be administered to children who react negatively not later than the 15th day after the test is made.

## 2. Compatibility and minimum intervals between doses of various vaccines:

a) The poliomyelitis vaccine is to be administered simultaneously with the DTP, DT, and TT vaccines; it is permissible to administer them separately without observing a specific interval between the doses of the poliomyelitis vaccine and the aforesaid vaccines;

b) The measles, mumps, and rubella monovaccines are to be administered simultaneously (in different places), or a 30-day interval between the doses of each of them is to be observed;

c) The hepatitis B vaccine is to be administered simultaneously with all other vaccines included in the immunization calendar or without observing a specific interval between doses; in case of simultaneous administration, the vaccines are to be injected in different places;

d) The BCG vaccine is to be administered simultaneously with the hepatitis B vaccine, with which it is compatible; in the case of the other vaccines, a 30-day interval between the doses is to be observed;

e) In testing for tuberculin sensitivity, after application of a live virus vaccine, a minimum interval of four to six weeks after the vaccine dose is to be observed;

f) It is permissible to administer simultaneously (in different places) the following vaccines: poliomyelitis, DTP, DT, and measles, mumps, rubella (monovaccines and trivaccines) in the case of children who are to be immunized (reimmunized) but who have not received the doses in the sequence indicated in the immunization calendar;

g) No intervals or medical contraindications are to be observed in administering tetanus toxoid for prophylaxis of injured persons or in administering hydrophobia vaccine to persons in danger of hydrophobia.

## 3. Intervals in the administration of human normal and specific immunoglobulins:

a) Immunoglobulins for prophylaxis of persons in contact with contagious patients or for therapeutic purposes are to be administered regardless of the interval of a preceding immunization or reimmunization that has been performed; given an interval of less than 14 days, immunization (reimmunization) with the live virus vaccines: measles-mumps-rubella monovaccine or measles, mumps, and rubella trivaccine is to be repeated at the earliest three months after the administration of the immunoglobulin; for persons in contact with virus hepatitis, this interval is six months (after an assessment of health status on the basis of the results of a laboratory examination that rule out the person's having had a protein-free form of virus hepatitis);

b) Live poliomyelitis vaccine, killed vaccines, and toxoids can be administered simultaneously with immunoglobulins and also at a different time, without observing a specific interval between the doses of the vaccines and the immunoglobulin.

### Footnote

1. toxoid = anatoxin.

### Cabinet Discusses Health Care Enterprises Support *AU1510175892 Sofia BTA in English 1714 GMT 15 Oct 92*

[Text] Sofia, October 15 (BTA)—The Council of Ministers today discussed a package of statutory instruments submitted by the Ministry of Health, the minister of health and deputy prime minister, Mr. Nikola Vasilev announced today.

In a week's time the cabinet is expected to reach a decision on the issue concerning the financial support of health care establishments till the end of 1992, Mr. Vasilev said. He believes the cabinet will probably decide to release an additional financial aid to budget-sponsored health care establishments according to their individual needs and indebtedness. Health care establishments financed by the municipalities will receive interest-free loans. According to data provided by the Ministry of Health, the normal operation of municipal-sponsored health care establishment necessitates 1,224,251,000 leva till the end of the current year. Other 473,780,000 leva will be needed to support health care establishment financed directly by the state budget.

The government adopted a decree amending the regulations on the application of the Public Health Act and the improvement of pharmaceutical supplies, Mr. Vasilev reported. The cabinet authorizes the minister of labour and social affairs to determine the order, conditions and categories of people entitled to free or partially paid medicines or medicinal foods on the basis of the minimum monthly income. The Medical Ministry will be responsible for the allocation of free and partially paid medicines for a number of diseases only.

Certain medical fees within the system of health care will also be changed. Students will be exempt from abortion fees. Other abortion fees, differentiated on the basis of incomes, will be increased from 30 to 300 leva and from 50 to 500 leva. The state will charge 3,500 leva for the

setting up of private medical establishments. The same amount will be charged for the establishment of private- and state-owned pharmacies with the exception of hospital pharmacies which will be exempt from this obligatory charge.

## YUGOSLAVIA

### Deputy Commander Protests Prolonging of Aid, Corridors

*AU2509080992 Sarajevo Radio Bosnia-Herzegovina Network in Serbo-Croatian 1700 GMT 24 Sep 92*

[Text] Stjepan Siber, deputy commander of the Headquarters of the Supreme Command of the Bosnia-Herzegovina Armed Forces, addressed a letter to the commander of the Sarajevo sector of the UN Protection Force [UNPROFOR], requesting that the letter be forwarded to General Satish Nambiar and the UN Security Council.

The Chetniks are obstructing the UNPROFOR's mandate to carry out surveillance and secure the corridors for delivery of humanitarian aid by setting various conditions, while the members of the UNPROFOR in Sarajevo—it seems to us—are supporting them. Although the commander of the sector and General Morillon agreed on the urgency of surveillance and the establishment of the communications, this task has been prolonged since 19 September, and it seems as though it will drag on until infinity.

Please take into consideration that Sarajevo will have no more bread as of tomorrow. There has been no water and electricity in the town for weeks, except for short interruptions of a few days. Hospitals are performing surgeries only during the day, as we do not have enough gasoline for the power generators to work at night for emergency surgeries. Legs and arms are being amputated without anesthetics, with the patients being fully conscious, just like in the middle ages. Hunger has already come to Sarajevo. The humanitarian aid is not coming, and even if we have had wheat and rice it would not be possible to cook the food without electricity, Siber's letter states.

The reason for this letter is the prolonging and nonimplementation of Resolution No. 776 of the UN Security Council, which envisages the arrival of 6-8,000 more blue berets, whose task is to see that humanitarian aid is delivered by land to the entire territory of Bosnia-Herzegovina. According to the drafted plan, the priority land corridor would be Ploce-Mostar-Sarajevo. From here, the corridor extends toward Zenica, Dobo, Bosanski Samac, and Bosanski Brod. The other direction stretches from Dubrovnik, via Trebinje, Bileca, Gacko, Foca, Gorazde, Rogatica, Sokolac, Zvornik, Bjeljina, to Brcko. From Foca, one direction runs via Trnovo to Sarajevo. The land corridor from Zagreb extends to Bihac-Bosanski Petrovac-Jajce-Donji Vakuf. From

there, it branches out in two directions—one toward Jablanica and the other, Novi Travnik and Vitez.

### WHO Official Warns of Autumn Starvation in Sarajevo

*AU0510133092 Paris AFP in English 1308 GMT 5 Oct 92*

[Excerpts] Sarajevo, Oct 5 (AFP)—[passage omitted] In Geneva, the U.N. High Commissioner for Refugees (UNHCR), the [Sarajevo] airlift organizer, said that 10 flights were expected on Monday, depending on the weather.

Also in Geneva, World Health Organization (WHO) special representative Donald Acheson said that if 240 tonnes of food a day were not brought into Sarajevo, children would start dying of hunger by the end of October and adults by mid-November.

"And in January we might expect to see pictures in one of the capital cities of Europe we have become familiar with in the Horn of Africa," he added. [passage omitted]

In the old city, the Moslem section, several buildings were hit including the department store Brusa Bezistan, used by the U.N. aid effort as a warehouse.

An AFP correspondent saw two dead civilians and three wounded at the store. [passage omitted]

### Aid Arrives In Sarajevo, Fighting Prevents Distribution

*AU0810121492 Sarajevo Radio Bosnia-Herzegovina Network in Serbo-Croatian 1100 GMT 8 Oct 92*

[Excerpt] Yesterday, five American and Canadian aircraft flew in 51 tonnes of food and medical equipment to Sarajevo airport through the humanitarian corridor.

According to what BH PRESS found out from the agency for the reception and distribution of humanitarian aid, there was no possibility of transporting the food from the airport into town yesterday owing to heavy fighting.

No land convoys with humanitarian aid arrived in Sarajevo yesterday. [passage omitted]

### POLITIKA Reports Tuberculosis Epidemic Among Refugees

*LD1410174492 Belgrade TANJUG in English 1118 GMT 14 Oct 92*

[Text] Belgrade, Oct 14 (TANJUG)—Tuberculosis has appeared among the refugees who came to Serbia from the former Yugoslav Republics of Croatia and Bosnia-Herzegovina, writes the Belgrade daily POLITIKA on Tuesday.

The Secretariat for Health Care of Serbia's Vojvodina Province said that 700 new cases of tuberculosis have been discovered in the province, writes the daily.

Over 400,000 refugees from Croatia and Bosnia-Herzegovina sought refuge in Serbia fleeing before last year's war in Croatia and the current conflict in Bosnia.

"Over the past six months, the incidence of tuberculosis in Belgrade has doubled, with the highest rise among the refugees," said Dr. Nebojsa Janovski, head of the Epidemiologic Department of the Institute for Lung Diseases of the Belgrade University Medical Center.

"For the first time, Serbia faces the "import" of tuberculosis from Bosnia and Croatia where its incidence in the past years was double and three-fold than that of Serbia," Dr. Janovski said.

"Tuberculosis has always followed poverty and wars," he recalls, warning that "a drop in living standards increases the prospects of tuberculosis affecting the non-refugee population."

Dr. Janovski suggests that all the refugees above the age of 18 be X-rayed and all the children tested for tuberculosis and that re-vaccination should be introduced where necessary.

## REGIONAL AFFAIRS

### New Dengue Campaign Financed by Italian Government

*FL0110185592 Bridgetown CANA in English  
1833 GMT 1 Oct 92*

[Text] Bridgetown, Barbados, Oct 1, CANA—The Pan American Health Organisation/ World Health Organisation [PAHO/WHO] on Thursday announced a U.S.1.8 million dollar campaign to combat dengue fever in the region. The move came amidst concern about a deadly type of fever—haemorrhagic dengue—in the Caribbean.

PAHO/WHO's Caribbean spokesman, Dr. Halmond Dyer, said cases of haemorrhagic dengue fever had been reported in Cuba, Venezuela, St. Lucia, and Aruba. Unless steps were taken immediately to deal with the situation, there could be a sharp increase in such cases in the region, he warned.

He said symptoms of the simple strains of dengue normally go away after a week, but when people became infected progressively with each of the four strains they could easily contract the haemorrhagic type. There is no vaccine against this type of fever. The new dengue campaign is being financed by the Italian Government.

## BELIZE

### Immunization Program Against Major Diseases Launched

*FL1010160792 Bridgetown CANA in English  
1520 GMT 10 Oct 92*

[Text] Belize City, Oct 10, CANA—Belize has launched a month-long immunisation campaign aimed at increasing the number of children protected against preventable diseases. With the slogan "Be Wise—Immunise," the campaign is geared towards mothers with babies under one year old. It offers immunisation against six [figure as received] major diseases—tuberculosis, polio, diphtheria, whooping cough, and measles.

Director of the Maternal and Child Health Department, Dr. Ramon Figuera, said that by the year 2000 Belize aims to immunise 98 percent of infants against tuberculosis and 95 percent against the other five diseases.

"These diseases have the potential to be life-threatening or can cause permanent disability if not prevented through immunisation," said Figuera.

Latest figures indicate that 76 percent of children under the age of one gained immunisation against measles during 1991 and more than 80 percent against the other five diseases. The Ministry of Health began an immunisation programme 30 years ago but it was not until 1985 that a significant advance was made which almost doubled the number of children covered, officials here say.

The figures have gradually increased since then through the efforts of public health officers and rural nurses and the use of a mobile clinic which visits villages on a six-weekly schedule. Last year Belize took part in the Caribbean wide initiative to give measles immunisation to every child under 15, and according to figures from the Ministry of Health, 84 percent of the children was reached.

## COLOMBIA

### Cuban Hepatitis-B Vaccine Administered

*FL2010150592 Havana Radio Rebelde Network  
in Spanish 1000 GMT 20 Oct 92*

[Text] More than 250,000 people, living in nine Colombian departments in which there have been cases of hepatitis-B, will be vaccinated during the first stage of inoculation against that terrible scourge. Rodrigo Rodriguez, head of the Colombia Ministry of Health immunization program, has reported that beginning in November, one million doses of hepatitis-B vaccine from Cuba will be administered to these people.

## CUBA

### Biomedicine Workshop With China Begins in Havana

*FL2909153592 Havana Tele Rebelde and Cuba Vision  
Networks in Spanish 0000 GMT 29 Sep 92*

[Text] The first workshop on Cuban-Chinese biomedicine was held today at the Center for Genetic Engineering and Biotechnology in Havana. This workshop began with an exhibit about our country's achievements in genetic engineering and biotechnology and the cooperation between Cuba and China in the medical, pharmaceuticals, medical equipment, and biotechnology industries and in traditional Asian medicine.

[Begin recording of PRC Embassy Charge d'Affairs (Li Xinghao)] We are aware that carrying forward our bilateral relations of friendship and cooperation, based on the principles of equality and mutual benefit, responds to the fundamental interests and aspirations of the Chinese and Cuban peoples and will result in benefits for our two nations. [applause] [end recording]

Cuban specialists demonstrated their success with the techniques of traditional medicine, reflecting the results of support and guidance provided by [words indistinct] in this field [words indistinct]. Another important aspect is the cooperation between China and Cuba in the field of neuroscience, which began two years ago between the Neuroscience Center at the National Center for Scientific Research and the medical universities of Beijing and southeast China, and where Cuban medical equipment to diagnose brain diseases and language development in children is already being produced.

**Villa Clara Reports Lowest Infant Mortality Rate**

*FL0710015792 Havana Tele Rebelde and Cuba Vision Networks in Spanish 0000 GMT 7 Oct 92*

[Excerpt] Villa Clara Province has the lowest infant mortality rate in the country according to reports from this province. With a little less than three months until the end of the year, Villa Clara Province has the lowest infant mortality rate in the country, with 6.7 deaths per every 1,000 births, a figure never before reached during similar periods.

Among the measures which make these results possible stands out the primary attention given to pregnant women at polyclinics, but mainly through the family doctor program, which covers more than 78 percent of the entire population of the Villa Clara Province. The careful attention of the specialists, who work in the infant care chambers, and the good discharge of the medical teams at the provincial infant hospital is also emphasized. [passage omitted]

**Hepatitis-B Infant Vaccination Campaign Begins**

*FL1410132492 Havana Radio Progreso Network in Spanish 1200 GMT 14 Oct 92*

[Text] Approximately 10,000 children born since January in Santiago de Cuba Province began

receiving today the initial massive dose of the Hepatitis-B vaccine. Infants born between January 1992 and today are receiving the vaccine at their respective health centers through the family doctor offices plan, polyclinics, and other facilities of the provincial health system—including the most remote mountain regions. The provincial hygiene and epidemiology center of Santiago de Cuba announced that in conjunction with this, the Hepatitis-B vaccine is being given to newborns at maternity and rural hospitals, and other centers beginning this week. The children will receive a second dose 30 days after the first dose. The third dose will be given six months later—in other words, next year.

**Medical Equipment Passes French Safety Tests**

*FL1211201092 Havana Radio Rebelde Network in Spanish 1800 GMT 12 Nov 92*

[Text] Medicid-#3E, which evaluates all functions of the central nervous system, has just become the first Cuban equipment to pass safety tests abroad. The system has received the favorable endorsement of the laboratories of the (Cien) Institute in France. This system is aimed at neurophysiological studies.

## ALGERIA

### Price Fluctuations in Medicines Examined

92WE0655B Algiers EL WATAN in French  
18 Aug 92 p 4

[Unattributed article: "Medicine: Price Fluctuations"—first paragraph is EL WATAN introduction]

[Text] The price of medicines includes three essential components: ingredients and packaging costs; direct labor costs; and manufacturing and quality control costs. These three components constitute the industrial cost price.

To this—according to research carried out by SANTE PLUS (a financial training and information magazine)—we should add return on equity to obtain the commercial cost price. Adding the manufacturer's profit margin, we obtain the manufacturer's wholesale price, exclusive of taxes.

According to SANTE PLUS research, the decree of 20 March sets maximum profit margins for the production and distribution of medicines at 15 percent net distribution margin, 20 percent wholesale, and 40 percent retail, and a percentage for the gross distribution margin.

Executive decree No. 91-153 of 18 May 1991 also sets limits on applicable profit margin rates at 30 percent for production, 30 percent for wholesale distribution, and 60 percent for distribution.

These percentages apply to products for which a ceiling margin was set, which include medicines, but it is not specified whether these rates apply to each and every product.

According to Mr. Ouaza, (private) pharmacist, prices have substantially increased in the past three years, as foreign currencies (French francs, dollars) became more expensive.

As a result, the firms in charge of supplying medicines blocked [sic] the authorities for a given period, while experiencing foreign-exchange losses, and banking institutions did not show any concern about it. This situation resulted in a banking overdraft for pharmacies, including 18 billion in interests for ENAPHARM [National Pharmaceutical Firm] alone, the same source reported, adding that, starting in August 1991, ENAPHARM decided that prices should reflect actual exchange rates, so that the prices of most medicines rose. For instance, Diamicron (antidiabetic) rose from 106.39 Algerian dinars in 1990 to 463.09 dinars in 1992.

Other factors also affect prices, e.g., a change of suppliers for reasons over which the importing firm has no control; some medicines were also imported although they were already marketed. For example: carbocysteine, which used to cost 9.33 dinars (when imported from Yugoslavia), rose to 21 dinars (foreign exchange loss),

then to 34.54 dinars (when imported from France Biogalenique); the same product is manufactured by SAIDAL [expansion not given] for 21 dinars and packaged in Constantine (ENCOPHARM [Constantine Pharmaceutical Firm]) for a price of 43.49 dinars.

The foreign exchange loss also contributed to these price variations; for instance, sulfaguanidine tablets, which used to cost 1.41 dinars, now cost 11.4 dinars. The 1:10 ratio is not justified by the foreign-exchange loss, and it seems that the price was increased for production cost considerations.

Another direct cause was the result of the decree of 20 March 1991 and decree 91-153 of 18 May 1991 concerning ceiling margins, and the emergence of new foreign distributors, such as the LPA [expansion not given] consortium of laboratories (SKF [expansion not given], Sanofi, Beecham, Synthelabo, Biochemie) that has been marketing 66 products in every form and dosage through wholesalers for two months already.

The pharmacies are said to have ordered these products, but they are not marketing them yet. The prices charged by LPA seem too high for users.

As an example, cimetidine tablets from the LEK [expansion not given] laboratories is priced at 26,81 dinars per box, while the price of tagamet (LPA cimetidine) is 736.81 dinars per box. On the other hand, Adepal imported by ENAPHARM [text missing] while Adepal imported by LPA is priced at 114.87 dinars.

Therefore, these price fluctuations, Mr. Ouazza concluded, are due to the erosion of the dinar, various changes in profit margins, four price changes by four (Algerian and other) manufacturers, and suppliers' diversity.

### Medical Supplies Ruined Due to Delays at Port

92WE0655C Algiers EL WATAN in French  
18 Aug 92 p 4

[Unattributed article: "Port of Algiers: Medicines Still Held Up"]

[Text] Large quantities of medicines are held up at the port of Algiers, exposed to the usual risks, because ENAPHARM, the National Pharmaceutical Firm of the center region is slow in taking delivery of its goods and in paying storage and warehousing charges, officials of the Port of Algiers indicated.

A port official told the APS that a large shipment of medicines, an estimated 1,300 tons, had recently arrived from France; yet, these goods remained a long time at the port, although storage and warehousing charges were quite low.

The same official pointed out that, for the first three days of storage and the warehousing of the medicines at the port, a transit tax based on the cargo weight is levied, at the rate of 1.36 dinar per ton if the goods are stored

outside warehouses. If they are stored in warehouses, the rate is increased to 3.09 dinars. After some time, the tax is based on other parameters, in particular the area taken up by the goods.

For his part, Dr. Ferhat, an expert at the Pierre and Marie Curie center of the Mustapha University Hospital Center, pointed out that several medicines will deteriorate in the presence of heat and moisture and therefore should not be left at the port without adequate packaging; in addition, the insects and rats that abound at the port could also damage the medicines that are most urgently needed by patients.

### Hospital Construction Awaits Supplies, Personnel

92WE0701B Algiers *REVOLUTION AFRICAINE*  
in French 13-19 Aug 92 p 45

[Text] The problems of the health sector are almost the same throughout the country, with only a few variations. The health system is sick, particularly in terms of the poor quality of service, particularly paramedical service. The responsible authorities talk about the absence of equipment and complain about customs and bureaucratic "red tape" and the major dependence of this sector on foreign countries, the only sources of specialized equipment.

When budgets are tight, as is the case at present, the situation becomes more difficult, it goes without saying.

In Constantine Ouahmed Abderrahmane, director of health, is not dissatisfied with the overall situation which, he emphasizes, is particularly alarming in the wilaya of Constantine. He says that, compared to other wilayas, Constantine does not have too much to complain about, although it suffers from a shortage of products (medicines and reactive products) for the recently opened kidney clinic. In this specific case patients suffering from kidney disease are responsible "on their own" for obtaining the four ampules of medicine necessary for their monthly treatment. The ampules cost 9,000 dinars each. You can imagine the drama involved in this!

There is also a problem with the maintenance of equipment, and major items (such as scanners) often are out of service for prolonged periods of time because of a replacement part which must come from a foreign country. Such a part is often slow in coming because the procurement procedure is slow.

There are AGI's [General Import Authorizations], but the customs procedure is cumbersome. A series of spare parts has not been received. At the home of M. A. Ouahmed there is a hope that this situation will be resolved. There is a positive sign in the fact that kidney transplants are now done under ideal conditions in the hospitals of the wilaya of Constantine. Another sign that gives real satisfaction is the opening of Zighout Youcef Hospital (with 120 beds). This hospital carries out surgical operations under the supervision of Professor

Mekhloufi. He also supervises Khroub Hospital (240 beds). It has a large maternity ward, noticeably relieving the pressure on other installations in Constantine, which have been much in demand until recently.

The kidney clinic has seven quite recently installed generators to make it possible for this section to function at full speed. The clinic is training 30 persons for the Souk-Ahras clinic. That is being done to relieve the pressure on the regional hospital. This is in spite of the continuous changes at the top level of the Ministry of Health, which has had four ministers in the course of two years.

### El-Riadh and El-Bir Hospitals in 1993

News that will greatly please the residents of Constantine, who want no more of the mediocre services of the old hospital, is that the two hospitals of El-Riadh and El-Bir will open in the near future. The two projects were undertaken in 1992. Their construction has been continuously delayed by the absence of construction materials and also of specialized equipment. These have become inaccessible due to inflation related to the decline in the value of the dinar. The decree setting up the two hospitals was signed in April 1992.

Only a few final touches remain to put these hospitals into operation, each of which has 120 beds. They will strengthen the public health service in a city, which has nearly 1 million people. They will have 240 beds in all and will have medical, surgical, and obstetrical services. The hospitals are officially scheduled to be opened in 1993.

The psychiatric hospital near Djebel El Ouahch is nearly ready. It will be opened during the coming months, according to certain sources.

There is still the difficult problem of hospital staff. In 1992 800 paramedical personnel have received quality training. However, most of them face unemployment. The problem of having too many trained people is now sharply felt. A satisfactory solution could be found by providing employment supported by the budget to those seeking work who have had three years of training. Jobs in the northern part of the country are the most sought after, but they are mostly filled, contrary to the situation in the southern areas, where a still growing shortage of employees is reported. There are vacant positions in the south, but support facilities are not available (housing, etc).

The wilaya of Constantine has made a great deal of progress in the field of health over the past few years. Figures are encouraging, showing one doctor for 2,812 people, one doctor for 6,172 people [as published], one dental surgeon for 1,500 people, and one pharmacist for 1,500 people!

Infant mortality has declined in a spectacular way. At present it is 48 per 1,000. International standards "have been reached." This lightens the serious picture of an

inadequate system for the provision of health services, which is controlled by a dreadful bureaucracy.

### **Drug Shortages, High Prices 'Affecting' Programs**

92WE0701A Algiers EL WATAN in French  
3 Sep 92 p 3

[Article by Hamid Tahri: "Medicines: Shortages and Seriously Limited Supplies"; first paragraph is EL WATAN introduction]

[Text] A few weeks ago we carried articles under the headlines of "Abnormalities" or "Seriously Limited Supplies." These concerned fluctuations in the prices of medicines, products that are "sensitive and strategic," but that are more and more beyond the reach of limited household budgets, if not totally absent from the display cases of pharmacies.

The sharp rise in the price of medicines and the shortage of some of them, despite the fact that they are essential, are no doubt one of the major concerns of the people. The complexity of the situation has become so serious that the National Observatory of Human Rights has raised this question, pointing out that, "for some months the prolonged shortages of various essential medicines have significantly compromised or brutally halted several health action programs. The prohibitive cost of medicine is discouraging to families."

However, what can be done when illnesses as serious as diabetes, high blood pressure, cardiovascular conditions, asthma, and chronic respiratory problems plunge patients and their families into a state of confusion? Developments in certain pharmacies in Algiers are instructive. Unfortunately, for example, people suffering from Parkinson's Disease cannot obtain supplies of Sinemet and Modopar, vitally needed medicines, which are notable for their absence from the pharmacies. Glucophage, Daonil, and Diamicran, which are essential for diabetics, do not seem to have any priority and are practically impossible for the great majority of people to find. Persons suffering from heart disease and high blood pressure still have to wait to obtain Risordon, Tromexane, or Sintron. There is no Bricanyl or Ventoline for those suffering from asthma.

On the other hand you have no trouble finding large quantities of Mercryl soap in the pharmacies at 136.36 Algerian dinars a bar. What good is this when Daonil, so much in demand for diabetics and costs less than 10 dinars, is totally unavailable in the market?

ENAPHARM [National Pharmaceutical Enterprise], like other companies of the same kind in the East and West, is unable to do anything about this situation.

This company, which has been autonomous for the past year, has an overdraft estimated at 2 billion dinars. To explain this enormous deficit, it takes into consideration unpaid accounts receivable due from several institutions. But is it its role to get bogged down in purely

commercial considerations, when sick people suffer in silence? The company is a prisoner of its status as a profit making business enterprise. It has moved far away from the category of "strategic and sensitive" companies in which it was originally included. From now on it will be treated in the same way as a company making pins! At the present value of the dinar costs cannot be brought under control, while in any case the prices charged are far from encouraging for the ordinary citizen. The situation is worse for certain products, whose date of validity is nearing an end. They continue to be sold in disregard of common sense. How can they play around so lightheartedly with the health of the ordinary citizen, who is criticized for being protected by the authorities?

In addition to public enterprises, there is the Algerian Pharmaceutical Laboratory [LPA], a private company set up in cooperation with several foreign pharmaceutical groups. The LPA prides itself on quality while charging prices that are out of reach and are practically equal to the rate of the dinar in the free market! The type of products available from the LPA is also rather selective.

Gardenal (for epileptics), which nonetheless costs four dinars a package, is not imported. The LPA prefers to market Depakine at 400 dinars a package. Profit considerations require this, and nothing forces the LPA to act in any other way. In the same way the laws of the market have allowed it to set up a distribution network handled by wholesalers whose competence in this field is not always so clear. This does not take into account the pharmacists who travel around the country, looking for products in short supply, not always in the interest of their patients (or customers!).

### **Promises Not Kept**

From the very beginning the LPA, which received the first license in this field from the Chamber of Commerce, announced that it was going to introduce Western technology into Algeria by manufacturing pharmaceutical products by the end of 1992. This was a rather ambitious idea, since its activity is limited at present to the sale of imported products, at prohibitive prices. Who keeps track of this? As far as the Algerian pharmaceutical industry is concerned, it only satisfies 8 percent of the needs of the Algerian people, due to a lack of raw materials. Can this situation remain unchanged indefinitely, when there are alternative solutions? What is to prevent the establishment of private companies owned by shareholders for the local manufacture of medicines?

With already existing equipment owned by the state and with raw materials purchased with the funds of the Algerian private sector it would be possible to have medicine available, with resultant savings in hard currency for the country. For example, the production of Doliprane, which is manufactured by Sidal and is sold for 10 dinars, has been halted due to a lack of raw materials. It has been replaced by the same kind of product imported by the LPA and sold for 74.46 dinars!

Why not get this industry going again, with the help of qualified Algerians?

The solutions considered recently by the government look like purely temporary operations, whereas the problem involves adopting a real pharmaceutical policy, directly involving the state, as the ONDH [expansion not given] suggests. The reduction in the variety of medicines by half (there are 700 medicines currently listed) is only a short-term solution, even though, according to the Ministry of Health, this is aimed at reducing dependence on foreign countries for imports of medicines. The problems involved in transporting 1,030 tons of medicine from the port in August are enough to make one laugh, although at the same time thousands of patients were waiting for medicine to relieve their suffering. And the medicines are still only slowly reaching the pharmacies!

Taking charge of this sector in all of its aspects (quality, stocks, distribution, and sales) is the only way to restore ethical standards and make the health sector more credible in a general way. It is not enough for this problem, which is political in nature, to be resolved by "band aids" or "magic solutions," as stated by a large number of people in this sector. If this problem is not resolved as a whole, the door will remain open to speculators and smugglers.

## INDIA

### Center Reviews 1983 National Health Policy

92WE0652A Calcutta *THE TELEGRAPH* in English  
28 Jul 92 p 1

[Article by Sona Rawla]

[Text] New Delhi, July 27: The government is reviewing the national health policy formulated in 1983 in order to make health services economically more viable and to reorient them to deal with the looming spectre of AIDS and the changes in the disease pattern resulting from the altering demographic profile of the nation.

The ministry of health and family welfare kicked off the review at a meeting in the capital on Thursday. A decision was also taken to hold monthly discussions with health administrators, professionals and academics to formulate various policy prescriptions. It is only after this that a policy paper will be drawn up.

The health secretary, Mr. R. L. Mishra, said the review had been initiated as a mid-course correction, after the data for the first phase of the existing policy—1983 to 1990—had become available. "There has been inadequate movement on several vital fronts and none on others. This review will identify these bottlenecks, alter the policy to deal with it and work out how to operationalise the changes," he said.

The primary concern of policy makers today is to ensure the cost-effectiveness of health services, said Mr. Mishra.

The resource crunch of the 1990s necessitated that public sector intervention be made in a manner calculated to bring maximum benefit to maximum numbers. "It just does not make sense for us to promote bypass surgery when an immunisation or an anti-tobacco campaign would be more effective," said Mr. Mishra.

Another modification needed in the policy, said Mr. Mishra, is in the field of old-age diseases. With the average life expectancy of an Indian increasing over the last decade, the disease-pattern of the country has also changed. The national health policy now needs to stress areas like cardiovascular diseases, diabetes, hypertension and cataract-induced blindness.

The updated policy will also be geared to fully battle the spread of AIDS which has assumed significant proportions.

Other elements which will also be stressed in the new policy are health education, Indian systems of medicine, the primacy of preventive over curative medicine and community participation in health services.

### Chaotic, Dangerous Conditions in Hospitals Told

#### Correspondents' Study

92WE0666A Bombay *THE TIMES OF INDIA*  
in English 3 Aug 92 p 13

Article by Praful Bidwai and Bachi J. Karkaria with reports from Sapna Bajaj Sawant (Bombay); Sakina Yusuf Khan and Ramesh Sharma (Delhi); Sudhir Vyas (Ahmedabad); Pushpa Iyengar (Madras); Shikha Bose (Calcutta); V.R. Mani (Trivandrum); Amit Dasgupta (Pune); P.K. Surendran (Nagpur); Sudhir Kalia (Chandigarh); Anil Sharma (Bhopal); Sharad Gupta (Lucknow); C. Lokeswara Rao (Hyderabad); Jagdish Bhatt (Shimla); Debashish Munshi (Guwahati); Manas Das Gupta (Baroda); Arun Kumar (Muzaffarpur)]

[Text] "God, keep me away from the police and from hospitals" became the daily prayer of a Nagpur resident after he spent two hellish months 'recovering' from typhoid.

Where does one begin cleaning up the monumental mess that public hospitals are in: with the once-in-a-while case of doctors removing out the good eye or the desperate every-day occurrence of a shortage of everything except filth and suffering? Can we pass without question the argument that we have too many problems, too few resources to afford the luxury of complaint?

Our correspondents' study of the apex institutions painfully reveals the shambles that public medical care is in, its low priority. State budgets are being slashed even as the serpentine lines in hospitals lengthen, and in every plan there has been a steady decline in the percentage earmarked for health—3.30 of the total outlay in the first, 2.10 in the fourth, 1.88 in the seventh.

Worse, medicine and equipment, the *raison d'être* of this service, must scramble for the crumbs, while salaries and other administrative expenses gobble up at least three out of every five rupees allotted. Haryana may spend a lavish Rs69.50 per patient, but in Madhya Pradesh this is an unbelievable nine paise. Strangely, in Uttar Pradesh last year, 70 percent of the Rs 22 crores sanctioned for hospital medicine remained unspent.

Kerala's finance minister admitted that the resources position was so critical that it would be difficult to continue to run public hospitals. Political pressure forced Maharashtra to remove the five-rupee registration fee this April, though most public hospitals have some paying beds. Hyderabad's Nizam Institute of Medical Sciences found it extremely difficult to implement its rule that those with an annual income of over Rs6,000 must pay for its services.

### Too Many Patients

Most of hospital's ills are nailed at the door of overcrowding. Delhi's All-India Institute of Medical Sciences (AIIMS) was built in 1958 to cater for 600 in its OPD; today, the number thronging here is 4,893 every day. Add to that the family members who accompany each patient and you have 30,000 people, plus 15-20,000 visitors for inpatients, milling around the hospital. Though funds are no problem and the institution is autonomous, a decline in hygiene and discipline is inevitable.

Mr. Nemichand Agarwal from Gwalior and his family have been camping in these corridors for the last 15 days, but the diagnosis of his five-year-old son's tumour-like formation is yet inconclusive. He says, "the line for the admission card begins forming two hours before the counter opens at 10 a.m. For everything it is a queue. They keep giving us dates and token numbers for every test. Today, it is X-ray, but we have already waited four hours for our turn. The AIIMS has now become like any other government hospital."

Shimla's Indira Gandhi Medical College is the only one in the state with an affiliated hospital, and patients have to queue up sometimes for a full day for the most routine test. In Lucknow, there are four times as many patients as in 1980, but beds and services have been upgraded only marginally.

At the Trivandrum Medical College and Hospitals, patients are forced to sleep on the floor, bedding they must bring from home; the 26,500-increase in the number of beds in government hospitals is nullified by the 3,100,000-increase in inpatients over the last 10 years. Pune's Sassoon General Hospital, with 1,500 patients for 800 beds, may be in less of a predicament, but Dr. Sunil Patil, secretary of the Maharashtra Association of Resident Doctors (MARD), called for a strike last year in protest against poor budgets and non-availability of equipment and medicine here.

The "occupancy rate" in Bombay is about 200 percent. Everywhere, the medicine, obstetric and orthopaedic wards are in the worst mess. At Baroda's SSG hospital, the shortage is not of beds or doctors but of nurses since many have been diverted to the new speciality wards such as cardiology and nephrology.

In some hospitals, there are three patients to a bed, so some have to sleep sitting. In Calcutta, one such mother fell on her newborn who suffocated to death. At the AIIMS OPD, a doctor can devote only 90 seconds to each patient. However, the Madras specialist who says he sees 40 patients an hour in a public hospital compared to four in a private one, claims that his experience helps him to identify instantly which of these 40 is at grave risk. "The speed does not indicate any qualitative short-changing in the treatment of the poor."

### Too Little Concern

Even if overcrowding is inevitable, it can be cushioned by less callous and rapacious attitudes. Besides, a significant part of it could actually be reduced by adopting inventory control and basic modern management. It does not seem to be understood by the state governments and municipalities which run these hospitals that convoluted bureaucratic procedures should not be applied to a department dealing in life and death, and that the rule of the lowest tender wreaks havoc through substandard medicine and equipment.

While it is generally acknowledged that resident doctors perform a herculean task in these Augean stables, the honoraries are perceived as merely using these hospitals to boost private practice.

In Bhopal, however, all the hospital staff is tarred. "They don't move, however much a patient may writhe in agony. In fact sometimes they pass caustic remarks," says Radha Tiwari, who was obliged to stay in the city's Hamidia hospital for three weeks attending to her husband's infective hepatitis. An OPD patient added, "The only advice a not-too-poor person gets is 'come to my house/clinic, I'll have more time to attend to you.'"

All this is presumably better than Guwahati's dilemma, where, three days a week, hundreds of patients and relatives descend on the station—not to attend some samaritan clinic run there but to take a southbound train. Railway officials say they account for a third of all passengers travelling from here to Madras. "We don't want to take the risk in an Assam hospital," says Nilima Kakoti. There being no superspecialisation faculty in Simla, all Himachal patients must travel to Chandigarh's PGI.

In Uttar Pradesh, only a greased palm will ensure that a dressing is changed or an injection given, even in such superspeciality centres as Lucknow's Sanjay Gandhi Institute for Medical Sciences. Everywhere staff has a vested interest in keeping the majority of equipment out

of order: less work and more commissions from the private investigation centres to which patients are diverted.

In Bombay's JJ Hospital, an electromyogram (EMG) machine for neurological investigations has lain in a state of disrepair for eight years, and the only functioning gastroscope on the campus was in the special AIDS ward. In Madras's Government Hospital, a doctor locked up expensive equipment during the six years that he was away; yet no action was taken against him when he returned.

Calcutta's hospitals are protected against the city's notorious loadshedding, but in Bhubaneshwar, operations are often performed by candle-light. In several Haryana towns, there are no night facilities for pathological tests, so emergency operations must be conducted without them. In Muzaffarpur's main hospital you can't get a blood sugar estimation done at any time. In Ahmedabad's huge Civil Hospital, an accident victim has to be taken to five different departments, all on different floors or even buildings before his injuries can be attended.

Gunwantrao Golke, a Nagpur coolie, must live with the aftermath of a collision that knocked off three of his teeth and part of the roof of his mouth. He cannot afford the Rs10,000 it would cost in a private hospital, and in the "government hospital they can only pull out teeth or clean them." However, in Uttar Pradesh, the chief of King George Medical College's dental faculty, Dr. Ashwini Dobhal, says that a dental chair and a whole set of instruments were permanently stationed at the chief minister's residence during Mr. Mulayam Singh Yadav's tenure.

The successor BJP government prefers to get its teeth into the transfers of medical staff. In Calcutta, doctors may antagonise the bosses of offensive, layabout unionised staff only at the risk of being banished for years into the mofussil. But West Bengal has found its own distinctive solution to political interference, an all-party committee oversees hospitals.

### Too Much Negligence

Once too often callousness spills into criminal negligence. Good legs have been amputated, wrong eyes gouged out. It will be a long time before the 13 deaths at JJ hospital caused by adulterated glycerine will be forgotten by the public, but bureaucratic memory is apparently much shorter. The dean, whom Justice Lentin denounced as unfit for any office, was recently appointed to head Pune's premier medical institution.

Bombay's hospitals are far cleaner than most, yet, though only three out of ten patients enter with an infection, twice as many ultimately get infected; not long ago 40 percent of deaths in Calcutta's hospitals were from hospital-related causes.

Equally damaging are the agitations by which, at any given time, some hospital or the other is crippled or even totally shut down. Certainly the grievances of resident doctors need to be locked into more sympathetically for they often work round the clock in the most trying conditions, and they bear the brunt of patient anger that now increasingly erupts. If their morale were higher, hospital conditions would improve dramatically.

### Lop-sided Care

If overcrowding lies at the root of the hospital crisis, it is because institutions built exclusively for referral cases are being used virtually as primary health centres. Don't blame the patient. Dr. Mira Shiva of the Voluntary Health Association of India says "the Bhore committee of 1943-46 had stressed primary health, but we ignored that. Today everything has grown in a distorted way—one AIIMS here, one cancer hospital there, no holistic approach at all."

In Andhra Pradesh, expenditure on PHCs and district hospitals is only one-third of what is spent on public hospitals. If the first don't have the most basic amenities and the second are little more than shoddy clinics, people will be forced to drag their pain-wracked bodies to the third. Would they opt for humiliation and worse if they had a choice?

Besides, public hospitals don't have to be placed where patients fear to tread. Their size and the medical talent they draw give them an unparalleled potential for community care. Institutions like Bombay's KEM have shown that professional standards, efficient management and cross-subsidising do produce results. Public hospitals are the only recourse of not just the poor, but a growing body of the middle class. Those who run and man them must learn that they are there to alleviate suffering, not to aggravate it.

### More Details, Outlook Grim

92WE0666B Bombay THE TIMES OF INDIA  
in English 3 Aug 92 p 1

[Text]—Forty-five people recently underwent cataract removal operations at Lucknow's famous King George's medical college hospital. Twenty-four of them lost their eyesight: The operation theatre was badly infected owing to overhead construction then in progress.

—"The civil hospital is worse than a slaughterhouse," moaned Mr. Jethabhai Patel of Wadgam village in Banaskantha when shifted to Ahmedabad's biggest hospital. "Death here is slow but agonising," he said just a few days before he died due to negligence.

—All India Institute of Medical Sciences (AIIMS), India's best-endowed (indeed pampered) public hospital, was yet again in the headlines: 45 patients died there between December 1990 and October 1991 in the anaesthesiology intensive care unit, two-fifths of them after routine minor operations.

—Not long ago, smart middle-aged Roosevelt was wheeled into the OT of the medical college hospital, Trivandrum's premier institution, for removal of a gallbladder stone. He came out a vegetable.

Horrifying as they are, these are daily occurrences in some of the best public hospitals in the country. The patients were victims of iatrogenesis (problems caused by the process of treatment—from iatros greek for physician).

They personify just one aspect—negligence, callousness, incompetence and lack of care—of the crisis of the health care system of the country. That crisis is pervasive. Public hospitals, on which upwards of three-fourths of our people depend are in an advanced state of decay and ill-health. They are run by people who are callous or corrupt or both, manned by overworked doctors and nurses, and exploited for personal gain by crafty administrators and corrupt politicians.

For millions of Indians, going to hospital remains a nightmarish experience: big crowds, long queues, confusing, maze-like layouts, incomprehensible instructions, tedious procedures, casual diagnosis, rough handling by sullen staff, rude physicians, bribe-taking by touts, complete absence of accountability and unconscionable delays.

Most working people think twice about visiting public hospitals simply because it means missing a day's work and wages.

Beds in Public Hospitals	
Year	Hospital beds per lakh of population
1970	60
1980	82
1982	82
1984	84
1986	90
1988	79
1992	?

Overcrowding has reached such horrifying proportions in the wards that most hospitals now regularly sleep patients on the floor. Most public hospitals are inherently patient-unfriendly and hopelessly mismanaged.

However, public hospitals are themselves victims of policies which give low priority to health, starve the medical system of funds, place low emphasis on primary health as opposed to specialised care, keep the system grossly understaffed by poorly paid junior doctors and nurses, neglect maintenance, create extreme overcrowding and ensure that the whole system goes to seed.

"It is as if there were a conspiracy under way to kill the public health system and allow private racketeering to

flourish," says Dr. Mira Shiva of the Voluntary Health Association of India. "The result is unacceptable neglect of health of our people."

Less than a third of our health budget is spent on primary health. Nearly 85 percent of it is spent on urban areas where only about a fifth of the population lives. These disproportions have grown.

The total health budget is less than one percent of Indian public spending—a level that compares unfavourably with Papua New Guinea or Zambia, Jordan or Tunisia, Chile or Mexico, Nicaragua or Cuba, Kenya or Ethiopia—leave alone China or Brazil.

India also has a disgracefully low population: Doctor ratio (2025), lower than Pakistan's 1987. Even worse, four-fifths of the doctors cater to one-fifth of the population. In place of three nurses per doctor, we only have one nurse for two. Although the number of beds per lakh of population has more than doubled in the past four decades, it is less than the recommended level and has been falling in recent years.

This is not all. Between 60 and 85 percent of our public hospitals' budgets are spent on salaries alone. The budgets are themselves being slashed—in Uttar Pradesh for instance from 10.5 to 3.3 percent of total spending. There are only a few states, e.g., Kerala, Tamil Nadu, which spend respectable proportions (e.g., 6 percent) on public health. More typically, others e.g., Madhya Pradesh, only spend 1.6 percent. The financial crunch has become worse with the new economic policies.

The net result: Only 30 to 70 percent of all hospital equipment works; Essential drugs are no longer stocked in most hospitals; even elementary facilities (e.g., to estimate blood sugar) are absent in most facilities.

Until recently the Centre if not the states, sought at least to maintain health spending. But Mr Manmohan Singh's last budget has changed even that: Allocation to programmes for control of malaria, filaria, TB, and iodine deficiency diseases have been cut by between 28 and 90 percent in real terms. The state governments are likely to take the cue.

The outlook for public health, then, is truly grim. Public hospitals are set to become unending purgatories, factories of illness, cesspools of corruption—unless a bold new policy initiative is taken.

## IRAQ

### Paper Reports Increased Recycling of Syringes at Hospitals

JN3009143092 Baghdad AL-JUMHURIYAH in Arabic  
28 Sep 92 p 8

[Article by Bushra Muhammad Shabib]

[Excerpt] There has recently been a growing phenomenon of syringes being recycled for medical use at health centers and hospitals, as well as by midwives and private nurses. Such practices have increased the possibility of many dangerous diseases being spread. In statements to AL-JUMHURIYAH, nurses, midwives, and medical workers attributed this phenomenon to the lack and acute shortage of syringes resulting from the continued unjust embargo on medicine and food. [passage omitted]

### Health Minister, Health Official on Diseases Among Children

JN1110135992 Baghdad INA in English 1335 GMT 11 Oct 92

[Text] Baghdad, Oct. 11, INA—The Childhood Care Body next Tuesday will mark the Iraqi Child Day which coincides with the 5th anniversary of the Iranian crime of bombing a primary school in Baghdad that claimed the lives of 29 pupils and the wounding of 218 others.

Dr. Umid Midhat Mubarak, health minister and head of the body said that the Childhood Care Body in Iraq has prepared a program on this occasion highlighting the challenge of the oppressive economic embargo imposed on the people and children of Iraq for more than two years.

The program will include various activities and performances including the staging of an exhibition for children paintings and products and a market for children clothes and toys.

On another level, the Ministry of Health has recently reported a noticeable increase in the cases of measles, severe diarrhoea, pneumonia and brain diseases among children.

Head of the Vaccination Department of the Ministry of Health Dr Muhammad al-'Ani blamed the spread of the diseases on the acute shortage of medicines, vaccines and antibiotics ensuing from the ongoing economic sanctions imposed on Iraq.

Dr. al-'Ani predicted that mortality rate among the patient will rise to reach some 20 percent, indicating that in cooperation with the Ministry of Education, the Ministry of Health has carried out a plan to immunize children against polomyelitis, whooping cough, tetanus and diphtheria.

He added that the economic sanctions have greatly affected and hampered the implementation of the ministry's annual immunization plan due to severe shortage of vaccines, indicating that Iraq has urged international and humanitarian organisations to provide it with badly needed vaccines and antibiotics.

## NEPAL

### Minister Answers Questions on Health Policy

92WP0304A Kathmandu THE RISING NEPAL  
in English 18 Aug 92 pp 1, 11

[Article: "Basic Health Services For Rural Poor Main Aim"]

[Text] Kathmandu, Aug 17 (RSS): Minister of State for Health Dr. Ram Baran Yadav said that extending basic health services to the rural sector for the improvement of the health status of the substantial rural population of the country is the main aim of His Majesty's Government's health policy.

Dr. Yadav was replying to various points raised during the debate on the appropriation head concerning the Health Ministry at the House of Representatives Sunday.

The government is pursuing a policy of directing the limited means and resources at its disposal toward the rural areas and encouraging the private sector to provide modern medical facilities commensurate with the growing needs of the urban sector, he said.

In line with this policy, works have been initiated on formulation and phase-wise implementation of necessary programmes under the national health service policy for the Eighth Plan, Minister of State Dr. Yadav said.

Noting that it is targetted to set up 500 sub-health posts in the country during the current fiscal year, Minister of State Dr. Yadav said that the budget has been allocated to set up 20 primary health centres in the current fiscal year.

As bound by the limited means and resources His Majesty's Government is not able to provide specific services like maternity service in hospitals in every district, he said, adding that general maternity services are being provided in the district hospitals whereas the specific services such as maternity, ENT services are being provided in the zonal and regional hospitals.

The government is effortful to provide X-ray lab and other equipment to the hospitals in the districts, he said informing that preliminary work will be done to establish two zonal hospitals during the Eighth Plan.

The number of doctors for enrolment in I.O.M. should be increased from 30 to 40 through coordination with Tribhuvan University in the course of producing high level skilled manpower like doctors and informed the House that B.P. Institute of Medical Science is to be set up in Dharan.

Remarking that the doctor's jurisdiction and the term of deputation has been explicitly mentioned, he said this will hope to some extent to meet the needs required in different health institutions.

Attempts are being made to give additional perks to those doctors who work in the far-flung areas and are non-practicing, he noted.

Dr. Yadav also informed the House that attempts are being made for assistance from the foreign donor agencies to develop research techniques in ayurved [as published] and for modernization of the Singhadurbar Vaidyakhana.

After replies by the Minister of State for Health, MPs demanding clarification were Dr. Banshidhar Mishra, Amik Sherchan, Rudramani Bhandari Sharma, Krishna Bahadur Mahara, Krishna Bahadur Shahi, Kul Prasad Uprety, Shiv Raj Gautam, Bijaya Subba, Tul Bahadur Gurung, Somnath Adhikari Pyashi, Mrs. Tham Maya Thapa, Laxmi Narayan Chaudhary and Hari Prasad Nepal.

In response to the clarification, Minister of State Dr. Yadav said that the government has taken seriously the issues concerning the sale of medicines of hoechst Nepal company on high prices.

Attention will be given to the promotion and expansion of ayurvedic science; he reiterated.

## PAKISTAN

### Health Minister Meets With Sudanese Envoy

92WE0697A Peshawar THE FRONTIER POST  
in English 11 Aug 92 p 4

[Article: "Pakistan, Sudan To Cooperate in Field of Health"]

[Text] Islamabad (APP)—Pakistan and Sudan will have extensive co-operation and co-ordination in the field of health and special efforts will be made in this regard.

This was agreed in a meeting of the ambassador of Sudan his excellency Abo Zaid Alhassan Abu Zahid with the minister for health, Syed Tasneem Nawaz Gardezi here on Monday.

The minister for health briefly highlighted the different ongoing health projects and also informed the ambassador about further plans in the field of health, particularly in relation to brotherly Muslim countries. The ambassador appreciated the performance of the ongoing health projects and stated that the brotherly ties between two countries were based on teaching of Islam. He further pointed out that the people of Sudan have deep-rooted attachment with Islam.

The minister said that the government was making special efforts to make Pakistan a truly Islamic welfare state and they had almost achieved this cherished goal. He further said that this government had great regards for the religious leaders and special legislative provisions being introduced for the supremacy of Quran and Sunnah.

The ambassador lauded the government's efforts for Islamisation, particularly Pakistan's stand and help for the Muslims of Bosnia.

He also extended invitation on behalf of the government of Sudan to the minister for visiting Sudan. He also showed interest to sign an agreement with Pakistan in the fields of vaccine production, control of malaria and other infectious diseases, exchange of medical expertise and professionals. At the end, the health minister and ambassador pledged to further strengthen the bilateral ties.

The meeting was attended among others by director general health, Dr. Syed Mohsin Ali and senior officials of ministry of health.

## UNITED ARAB EMIRATES

### Statistics on Nurses Based on National Origin

92WE0462A Al-Shariqah AL-KHALIJ AL-'ARABI  
in Arabic 18 Apr 92 p 2

[Article by Salam Abu Shihab]

[Text] Abu Dhabi—A report issued by the Ministry of Health stated that there are about 5,000 nurses working in the ministry's facilities at the state level, only 170 of whom were citizens. Thus, the percentage of citizen nurses working for the ministry is only 3.5 percent.

The report indicated that the expatriate nurses are of 14 nationalities:

- Indian: 1,899 nurses, 39.2 percent;
- Egyptian: 589, or 12.1 percent;
- Filipino: 559, or 10.2 percent;
- Palestinian 356, or 7.3 percent;
- Pakistani: 255, or 5.3 percent;
- Jordanian: 248, or 5.1 percent;
- Sudanese: 235, or 4.8 percent;
- Somali: 183, or 3.8 percent;
- Syrian: 132, or 2.7 percent;
- Lebanese: 87, or 1.8 percent;
- Bangladeshi: 33, or 0.7 percent;
- Yemeni: 26, or 0.5 percent;
- Tunisian: 18, or 0.4 percent;
- Other nationalities, specifically European or Eastern: 123, or 2.5 percent.

The report explained that 55 percent of nurses working in the Ministry of Health and the institutions under it are of foreign [non-Arab] nationality, and that 2.5 percent of them are of European nationality or from Eastern states.

It came out in the report that 46.2 percent of the nurses who are citizens work in jobs as assistant technicians and nurses' assistants, and about 50 percent of the nursing staff work in skilled technical positions, of whom 36.6 percent work as assistant technicians, and 11 percent work in jobs as technician in charge and first technician

in charge, and that only 12 nurses work in higher administrative nursing positions, which are: head nurse and assistant head nurse.

The report indicated that these nurses work in 29 hospitals, of which 23 are general hospitals and 6 are specialized hospitals. They also work in 93 primary health care centers, in addition to school and dental clinics. Thus, the level of nursing services in the state is estimated at one nurse for every 439 persons. But within the primary

health care services, the rate of nursing services differs, reaching one nurse for every 5,315 persons. That is because many of the health services in these centers are offered by doctors. There are 232 doctors in the health centers, compared to 347 nurses.

It mentioned that 70 percent of the nurses have a nursing diploma, and only 9 percent have obtained a bachelor's degree in nursing.

### **Failure to Vaccinate Results in Rise of Infectious Diseases**

92WE0587E Moscow IZVESTIYA in Russian 1 Jun 91  
Morning Edition p 2

[Article by Lidiya Ivchenko: "We're Going to End Up With an Epidemic If We Ignore Immunizations"]

[Text] Doctors are troubled: The number of cases of infectious diseases that several years ago we almost forgot existed is growing. This year, 904 persons have already gotten diphtheria, to include 227 children; 6 out of 16 that have died were children as well. And it was quite recently, after all, that diphtheria was recorded in the republic as only sporadic cases. In Moscow for example, there was not a single case of it in 1975, while in 1991 as many as around a thousand persons had it. The pattern is also the same with measles, whooping cough and poliomyelitis.

The status of our collective immunity, which depends on immunizations, is the reason. Things are not going as well as they should with immunizations in our country: Parents are resisting vaccination of their children. This is why specialists turned to the mass media for help. "Without your participation, we will be unable to enjoy any great success in this effort," journalists were told at a press conference by A. Monisov, chairman of the State Epidemiological Inspection Committee under the president of the Russian Federation. "Only a proper information program can persuade people that refusal of preventive vaccinations could do damage not only to the health of their children but also to the health of many others...."

For the sake of fairness it must be said that the press did have something to do with this "antiimmunization" sentiment. There were articles in the newspapers and radio broadcasts describing the poor quality of our vaccines and the harmful components they contain, ones which allegedly cause serious infections and complications.

The percentage of immunized children began decreasing abruptly. This is even though the Russian law "On the Epidemiological Welfare of the Population" makes immunizations against diphtheria, whooping cough, tetanus, poliomyelitis, measles and tuberculosis mandatory.

In Europe, 90-95 percent of children are immunized against poliomyelitis and diphtheria. Twenty-six countries in the European region are totally free of poliomyelitis, and sporadic cases are registered in some. But in the CIS countries, in which a third of the European population lives, 90 percent of all cases of poliomyelitis are documented. In St. Petersburg for example, less than half of the children are immunized, even though poliomyelitis vaccine is the most harmless, and it does not produce side effects. As a result two of "our own"—not imported—cases of poliomyelitis appeared in the city for the first time in 30 years.

Complications from immunizations do of course occur, doctors admit, though significantly less frequently than people say. There are no absolutely harmless vaccines, no matter how good and "pure" they might be (by the way, our vaccines correspond to international standards). But reactions and complications are different things: Reactions are unavoidable, they are a natural process of development of immunity. Complications are another matter. They are all recorded and analyzed. Last year 446 cases of complications following immunizations were registered. No one died from them. This is a negligible price to pay for epidemiological well-being. There is good reason why the World Health Organization adopted an expanded immunization program which all of the world's countries are adopting.

Even without this, our infant mortality per 1,000 births is among the highest in the world. If we go on ignoring prevention as well, we are going to have an epidemic.

### **High Incidence of Tuberculosis in CIS Rocket Forces**

92WE0587B Moscow NEZAVISIMAYA GAZETA  
in Russian 16 Jun 92 p 6

[Article by Andrey Bayduzhiy: "Tuberculosis—A Russian Disease: Prisoners and Officers Are Its Most Frequent Victims"]

[Text] Diseases that we no longer think about are beginning to remind us of their existence with increasing frequency. Tuberculosis control measures were discussed at a recent meeting of the board of the Russian Ministry of Health. For the first time in several decades the curve of this disease began crawling upward in the republic. Aleksey Priymak, general director of the Fiziopulmonologiya Scientific-Production Association, stated that there were several reasons for such growth: weakening of the fight against tuberculosis, decentralization of public health, and a lack of money. An uninformed public was a factor of some importance as well: A significant number of people do not even suspect that the disease is infectious. Tuberculosis has always been thought of as a disease of poor nutrition, and in the opinion of physicians, the present economic crisis is yet to have a substantial impact here.

Each year 11,000-12,000 persons die of tuberculosis in Russia. As of the beginning of 1990, 298,000 patients were registered in the republic, with 95,000 of them capable of releasing bacteria. But the actual figures are two to three times higher. According to Aleksey Priymak up to 70 percent of tuberculosis patients are not accounted for. Such problems with official statistics are explained by the unique features of tuberculosis patients. Two-thirds of them are representatives of the so-called antisocial groups—bums—chronic alcoholics and persons serving sentences in labor camps. It is extremely difficult to keep records on them. The number of tuberculosis patients increases sharply in Russia as we travel from south to north and from west to east. Given an

average of 34.2 patients per 100,000 residents in the republic, in Siberia and the Far East there are as many as 276 cases of illness among the same 100,000. Tuva, Buryatia and the Transbaykal are almost continuous foci of tuberculosis. In European Russia, a most unfavorable situation has evolved in the Northern Caucasus.

Small ethnic groups suffer the most from tuberculosis. Morbidity among them is five times higher in steppe regions and 10 times higher in the Far North than the country average. For the sake of fairness it should be noted that the elevated morbidity observed among certain ethnic groups is characteristic of not just our country alone. In the USA, where there are an average of 9.2 cases of illness per 100,000 persons, this indicator is 315 among persons of Vietnamese and Cambodian origin.

It would take 15 million examinations a year to set up an efficient system of preventing tuberculosis among the risk groups. Today this figure is five times smaller. Only half of the population regularly undergoes fluorography. In order to examine everyone, we would need another 4,000 X-ray machines. However, specialists are not unanimous in this regard. A proposal was made at the board meeting to do away with the practice of universal fluorographic examination of the population altogether. There are rather substantial reasons for this: Each year fluorographic irradiation elicits around 2,000 cancer cases in Russia.

The other point of view, which Minister of Health Andrey Vorobyev supported, is that the dose received by the patient during an examination is allegedly negligible when compared to the overall radiation "menu" to which a Russian citizen is exposed. At the same time, because of an insufficient number of fluorographic examinations, each year, in his words, around 30,000 cancer patients and the same number of tuberculosis patients are revealed.

A good amount of time was devoted at the board meeting to discussing the situation that has evolved in corrective labor institutions. Morbidity is 35-50 times higher here than on the outside. In turn, isolation cells have become seed-beds of infection in places of confinement.

Because they are extremely overcrowded, patients are kept in the same cells with healthy persons, and during this time they manage to infect all the rest. The percentage of recidivists is especially high among patients: The consequences of numerous prison terms have an effect. By the way, some prisoners have no desire whatsoever to protect themselves from tuberculosis. Presence of this disease is one of the signs of membership of a prisoner to the highest caste of the criminal world. Moreover, tuberculosis brings many practical advantages to its possessor as well: release from labor, an improved diet, easier conditions. A unique sort of business has even flourished on this soil in colonies: For a

certain sum, one desiring to do so may purchase tubercular phlegm. Upon release, this category of patients is not put on record as a rule. According to the Ministry of Health there are 30,000 ex-prisoners roaming Russia today with open forms of tuberculosis. In the opinion of hospital workers of corrective labor institutions present at the board meeting, the law presently being drafted on tuberculosis must include an article regarding responsibility for deliberate infection and self-infection.

Next to prisoners and bums, strange as it may seem, officers of CIS strategic forces carry the greatest risk of catching tuberculosis: Missile sites have the same problems as prisons.

Speaking at the conclusion of the discussion, Andrey Vorobyev promised that in the immediate future the Minister of Health will ask all interested departments to draw up a unified government tuberculosis control program. Besides the Ministry of Internal Affairs, agricultural administrative organs will take part in its implementation as well: In 1991, 1,200 farms maintaining animals infected with tuberculosis were registered on the republic's territory.

### **Pediculosis on Rise in Russia**

*92WE0587C Moscow TRUD in Russian 4 Jul 92 p 39*

[Article by I. Nevinnaya: "There's Good Reason to Scratch Your Head"]

[Text] "Looks like it's a goner. Look, it's doing a headstand with its legs up."

"No, it's just attaching itself...."

**The laboratory table was set with flat glass vessels—Petri dishes. And in the dishes, beneath the microscope, lice treated with yet another agent crawled about.**

I didn't come here to the laboratory of the Scientific Research Institute of Preventive Toxicology and Disinfection out of nothing to do. Reports from different regions regarding outbreaks of pediculosis (or, as the people call it, lousiness) have grown more frequent in recent times. In Yekaterinburg for example, a special team was established under the disinfection station, and in 5 months it has been credited with 314 emergency calls to treat pediculosis foci. In Moscow, 600 beauty shops were inspected, and it was discovered that they were a possible seed-bed of infection. Children in nursery and secondary schools are becoming infected continually and totally. It looks like lice are spreading unhindered over our vast spaces.

My attempts at clarifying what cities of Russia and other contiguous states were exposed the most to this invasion were unsuccessful. First of all, information is no longer coming in to the institute from the former republics. And second, even the figures that are available are believed by specialists to be extremely understated. It was then

that I asked for the names of cities and rayons that were not experiencing any problems. Well, there aren't any in Russia.

**In the laboratory I visited, lice—don't be surprised!—are coddled, tended, fed donated human blood, bred and "raised." Scientists are studying them. They are seeking and developing agents with which to control the insects.**

**Is there in fact something to seek and invent?**

"Absolutely," believes A. Frolova, a scientific associate of the institute. "If head lice—and they are the most widespread—were carriers of typhus and trench fever, the country would simply have died out by now. Luckily nature has decided otherwise. The probability of transfer of infectious diseases by head lice is small. When they bite, they do of course cause intense itching. This is why pustulous diseases arise when the bites are scratched."

Quite recently a medical checkpoint stopped a drifter from the Baltics with pediculosis so far gone that his head was covered by a baked-on crust of dirt, purulent secretions and long-unwashed hair. And beneath this crust his head was swarming with lice.

"Nor are ideas about crab lice always correct," A. Frolova continued. "For some reason, most people think that you can get them only through sexual contact. Yes, that is the main pathway. But consider this example: One young boy returned from Pioneer camp infested with crab lice. This tiniest variety of lice that is barely visible with the unaided eye lives not only in the groin and pubic region but also in the armpits, the beard, whiskers and even the eyebrows and eyelashes. The child had them on his head. Clearly he was not infected by sexual contact. But how, then? Possibly in the bath or swimming pool. Perhaps he slept in the same bed with someone who had them, or on dirty bedding."

The body louse, which lives in the folds and seams of underwear and clothing, is the most dangerous of all. It was the cause of the typhus epidemics that have mowed people down during wars. The fact is that lice are very sensitive to temperature changes, and therefore whenever a sick person would become feverish, the insects would abandon their temporary home and crawl away in search of a new one, thus spreading infection.

While body lice have represented a negligible percent of the total number of revealed cases in quantitative respects, they are now being detected with increasing frequency. This cannot but cause concern. We shouldn't relax on the grounds that there have been no typhus epidemics in our country since the last war. After all, people who had carried this terrible disease are still alive. Specialists know that many years after recovery, the disease can recur, flare up once again, as so-called Brill's disease. And if at this moment a sick person is infested by body lice, the danger of an epidemic rises tenfold. I don't want to frighten anyone, but facts are facts: Cases of both body lice and Brill's disease have been recorded

in Moscow. Imagine what can happen if two such cases happen to come together at the same time?

Pediculosis has been around as long as mankind itself. And strange as it may seem, in some places people are so tolerant of coexisting with the parasites that they feel presence of lice in their hair to be a sign of health.

But that's a fact from the strange and unusual. Here, though, is one that isn't all that strange and unusual: Associates of one of the capital's largest department stores reported to Moscow's disinfection service that after a group of new dresses had arrived and were tried on by customers, the sales clerks discovered lice on the clothing.

It would seem that everyone is aware of the cause of pediculosis: absence of elementary hygiene. However, I wouldn't want to be too hasty in accusing fellow citizens of slovenliness and uncleanness, when a bar of household soap costs 13 rubles and cheap toilet soap costs 7 rubles.

These are of course not the best of times. In all periods of instability, mass migrations and wars, lice have felt themselves to be free. And today, the millions of refugees have been joined by tens of thousands of the unemployed, destitute, impoverished and homeless.

Finally, the availability of pediculicides in the country is "lousy."

Scientists are conducting the experiment which I described at the beginning of this article in order to find a new substance that would kill the parasites but would be relatively harmless to man. The plant that manufactures the ingredients of such an agent is stingy, and therefore scientists are forced to seek new variants of reagents that are cheaper and not as scarce.

The lotions Lontsid and Perfolon and a 20-percent water-soap suspension of benzylbenzoate are currently produced against pediculosis. On rare occasion, pharmacies carry hellebore water and special pediculicidal tablets. Drugs are few and scarce, but disinfection stations should always have them.

Specialists warn us of another danger arising in connection with pediculosis—the possibility of intoxications. Very often, even people who use the preparation with permission do not follow the proper dosage or the time of exposure, and wind up in the hospital. For example, scientists who tested several types of Chinese pencils that have become popular established that their ingredients include substances from the cyanide group that are very poisonous and dangerous.

"It would be better to dig out grandmother's recipes—water-soap-kerosene emulsion, and vinegar dressings," said A. Frolova. "They don't kill lice, but only make it easier to comb them out. A 5 percent boric ointment could be used on adults. But the surest remedy for people who have allergies and skin diseases is frequent combing."

To be honest, in sampling the "delights" of pediculosis, communicating with specialists and digging through literature, I submersed myself so deeply into the topic that from time to time I couldn't help scratching. My associates began looking at me suspiciously, and avoiding me without making it look like they were. Seeking consolation, I turned to Dal, that fountain of folk wisdom, and in his works I read: "No one can taste real grief until he is bitten by his own louse." This, as I see it, fits the present situation better than anything else can. The time has come "to scratch our heads" and find a way to get rid of the infestation.

### **Program Examines Psychological Control Experiments**

*LD2209194992 Moscow Teleradiokompaniya Ostankino Television First Program Network in Russian at 1920 GMT 17 Sep 92*

Teleradiokompaniya Ostankino Television First Program Network in its "Novosti" newscast, broadcasts a 40-minute program entitled "Black Box", dealing with the devices and drugs used in the former USSR to influence and bend the human brain.

[Editorial Report] The program begins with the presenter noting that apparently a program for implementing methods of psychological influence was submitted to then prime minister Ryzhkov in 1987. There were plans to use psychological influence for military and economic purposes. The programme goes on to deal with the methods of influencing people's physical and mental condition, and exerting influence on their decisions. An unidentified man comments on the work which was carried out to implement this program. He says that a commission, consisting of 20 people, was set up. There were six academicians among them and a scientific council, led by Academician Kotelnikov, was also set up.

He goes to say that the council did not make much headway in its work due to the fact that it was totally rejected by academic circles. There were similar programs in Ukraine, led by Academician Trifilov, and in Moscow led by Dr. Ernest Andriankin. The speaker says Andriankin was the head of a department dealing with theoretical problems connected with designing logical languages for propaganda purposes, and he researched a program for exerting psychological influence on the enemy in Afghanistan. Another unidentified man says that his theory has always been that it is better to exert psychological influence than to shoot.

The program goes on to describe other research programs which have existed and still exist. The presenter dwells on the danger of these research programs ending up in the hands of the wrong people.

Doctor of Technology Valeriy Kanyuka, the first interviewee identified by caption, emphasizes that one must be very careful with these research programs. "Until the

world's states reach some agreement, until an international legislation banning psychological and physical steering of intellect and influencing people, a moratorium on this ground work is needed," he says. "Instead of nuclear weapons we will get a new form of weapons, a more frightening one, one which has a frightening name—it is called ecologically pure weapons".

Kanyuk then says that influencing the human brain, and subsequently genetics, could be extremely dangerous. He then recalls cases of using drugs for political motives. The video shows footage and information about the attempt on President Marcos of the Philippines in March 1967. The commentary says that ground work done in the former USSR allows the mind to be split in to 13 personalities.

Igor Mogila, a journalist for the TRUD newspaper, talks about a Soviet hypnotist and his involvement in military issues. The video shows footage about an incident involving the U.S. submarine "Nautilus", which took place on 25 July 1959.

Various other unidentified people involved in the research are interviewed. One, identified by caption, is Yuriy Malin, a biomedic and a former consultant to the USSR National Security Council. Malin gives examples of similar work done in the United States. According to the NEZAVISIMAYA GAZETA, he says the CIA and the KGB agreed in April 1990 on joint research in the sphere of psychological influence—the agreement number is 174-90/16, he says.

The program concludes by showing footage and information about the involvement of the CIA in Carter's inauguration.

### **Admission to International Red Cross Discussed**

*LD2809112492 Kiev Ukrayinske Radio First Program in Ukrainian 0500 GMT 26 Sep 92*

[Excerpts] The question of the critical situation with regard to the provision of immunological preparations was discussed on 25 September at a session of the National Security Council of Ukraine. [passage omitted]

A wide range of issues was discussed at the session, among them the necessity of resolving problems of drinking water. The necessity of producing medicines was defined as one of the priority areas for state activity and also the resolving at an official level of the admission of Ukraine's National Red Cross Committee to the International Community. [passage omitted]

### **Security Council Discusses Immunobiological Issues**

*AU3009175592 Kiev HOLOS UKRAYINY in Ukrainian 29 Sep 92 p 1*

[Unattributed report: "In the National Security Council"]

[Text] On 25 September, the meeting of Ukraine's National Security Council discussed the question "On the Extreme Situation That Has Taken Shape in the Provision With Immunobiological Preparations and on the Imminent Spread of Infectious Diseases in Ukraine."

A broad circle of issues was discussed at the meeting, including the need to resolve the problem of drinking water, to consider the production of medicines as one of the priority trends in the state activity, and to officially decide whether the Ukrainian National Red Cross Committee is joining the international association.

Leaders of central organs of state power and leading scientists took part in the meeting chaired by Ukraine's president L.M. Kravchuk.

#### **Environmental Situation Worsens; Birthrate Declines**

OW0810130892 Moscow INTERFAX in English  
1101 GMT 8 Oct 92

[Following item transmitted via KYODO]

[Excerpts] Data related to the state of the nation's health as well as the environment in Russia in 1991 are worrisome. This was indicated by the Moscow news conference on Wednesday [7 October] held by the presidential advisor on environmental problems Aleksey Yablokov, the Minister for Natural Resources Viktor Danilov-Danilyan, the Chairman of the State Committee for Sanitation Yevgeniy Belyayev and the President of the Academy of Medical Sciences Valentin Pokrovskiy.

The rate of population growth continues to shrink. While between 1980 and 1988 the population grew by about one million a year, in 1991 the figure dropped to 200,000. While the birth rate has been falling, the death rate has been growing. In 1991 the birth rate per one thousand of the population was 12.1 and the death rate 11.4. The number of territories where the death rate exceeds the birth rate grew from 10 in 1989 to 29 in 1991. The average life span has remained practically unchanged: 64 years for men and 74 for women. [Passage omitted]

The environmental situation is also worsening. Only 15% of urban dwellers live in territories with pollution below the permitted norms. Almost half of the drinking water does not meet hygienic requirements. The annual dumping of polluted water increased from 15 bn [billion] cubic meters in 1985 to 28 bn in 1991.

In 1991 in 84 cities with a combined population of 50 mn [million] air pollution exceeding the norm 10 times and more was registered many times. [Passage omitted]

#### **Special Treatment Center for Chernobyl Victims Opened**

LD2210204192 Moscow Radio Rossii Network  
in Russian 1700 GMT 22 Oct 92

[Text] A special unit for treating those suffering from the effects of the Chernobyl disaster, the first of its kind in Russia, has opened at the Ryazan oblast clinical hospital. According to ITAR-TASS, over 200,000 inhabitants of Ryazan oblast live in areas affected by radioactive pollution.

#### **President Issues Directive on Infectious Diseases**

AU1211110492 Kiev HOLOS UKRAYINY in Ukrainian  
4 Nov 92 p 2

["Ukrainian Presidential Directive on Measures to Prevent Infectious Diseases and Provide the Population With Immunobiological Preparations" issued on 26 October]

[Text] In order to intensify the struggle against infectious diseases, to prevent cases of poisoning and death, and to provide the population with immunobiological preparations, the following must be done:

1. Ukraine's Ministry of Health, the government of the Crimean Republic, as well as oblast, Kiev, and Sevastopol city state administrations must take urgent measures to ensure proper sanitary and epidemiologic conditions, a decrease in the risk of mass infectious diseases and poisoning, and an improvement of the level of state sanitary supervision.
2. To determine that the chief state sanitary physician of the Crimean Republic, of oblasts, of Kiev, and Sevastopol must hold the post of deputy head of, respectively, the government of the Crimean Republic or of local state administration.
3. The Cabinet of Ministers of Ukraine must do as follows:
  - To ensure priority development for enterprises of the Ukrmedbioprom [Ukrainian Medical and Biological Industry], enabling them to expand the manufacture of immunobiological preparations and laboratory equipment by providing them with means and material and technological resources on a preferential basis;
  - to elaborate and adopt, by 1 February 1993, the National Program for Preventive Immunobiological Treatment of Ukraine's population.
4. Ukraine's Ministry of Internal Affairs must provide all-round assistance to those officials who are implementing the state sanitary supervision in their work to prevent and correct violations of sanitary norms and rules.

Ukraine president L. Kravchuk

Kiev, 26 October 1992

## FINLAND

**Excess Hospital Equipment Sent to Russia**

92WE0694B Helsinki HELSINGIN SANOMAT  
in Finnish 10 Sep 92 p 5

[Unattributed article: "Obsolescent Hospital Equipment to Russian Karelia"]

[Text] In connection with an upgrade of hospital equipment at the South Saimaa Central Hospital, hospital supplies and equipment will be sent in late September to the area of Aunus in Russian Karelia. According to currently available information, the equipment will be picked up by representatives for Karelian hospitals on 22 September. They will then be given an opportunity to take whatever hospital equipment they need from South Karelia Hospital District's store of used and fully depreciated equipment. Available equipment includes, among other things, hospital beds, nightstands, washbasins, autoclaves, and operating-room light fixtures. The equipment is used, but in working order. Equipment with no takers will be dumped.

## GERMANY

**Seehofer Views Health Insurance Reform**

AU0710181392 Frankfurt/Main FRANKFURTER  
RUNDSCHAU in German 7 Oct 92 p 5

[Interview with Health Minister Horst Seehofer by Peter Ziller; place and date not given: "The Coalition Groups Have Stood Firm So Far"]

[Text] Ziller: Mr. Seehofer, for how many years will the contributions remain stable after the—as you put it—"profoundest reform work in the history of legal health insurance" has passed the Bundestag and the Bundesrat?

Seehofer: We have the chance to achieve financial stability in legal health insurance for two to three legislative periods. This, however, also depends on economic growth—and I will say it again today—that we need a third reform stage in the mid-nineties as well. Then there is the question of what must be secured in solidarity and for what one can be responsible for oneself.

Ziller: There is already a hail of protests. Are the coalition groups standing by the Lahnstein compromise?

Seehofer: The interest groups are once again fully active. I am fully aware of this. There is a shower of calls, but so far the coalition groups have stood firm.

Ziller: What would be the consequences for you if the project failed?

Seehofer: Oh, I do not proceed on the assumption that it will fail. Therefore, I have not reflected what would happen then.

Ziller: How great is the sacrifice that the 1993 health reform demands from the insured? You are talking of DM3 billion and the Social Democrats, about DM1 billion.

Seehofer: Together with additional payments and benefits that are not covered, the insured will be burdened with about DM2 billion. In addition, the voluntarily insured retirees will be burdened with an additional DM700 million.

Ziller: What are these burdens in detail?

Seehofer: Next year they will amount to DM1.3 billion in the field of drugs and approximately DM70 million in the hospital sector. In addition, payments for artificial dentures valued at about DM650 million will be eliminated from the catalogue of the legal health insurances.

Ziller: Regarding artificial dentures, the great expert coalition of Lahnstein demands smaller sacrifices from doctors and technicians than was first planned by the Christian Democratic Union/Christian Social Union [CDU/CSU] and the Free Democratic Party of Germany [FDP]. The base year for the fixed smaller deductions from their fees is now 1992 instead of 1991. Will you still raise the desired savings volume of DM11.4 billion?

Seehofer: According to cautious calculations, I am convinced that we will achieve around DM11 billion. I cannot tell you the exact figure because at the moment all our experts are carefully checking the individual measures.

Ziller: You said in June that in the long run the building laws of the social state—solidarity and subsidiarity—must be redefined. Social justice and responsibility must be brought into a new equilibrium with a view to Germany's age structure and medical progress. Will this also be valid after Lahnstein?

Seehofer: With this reform work, the greatest reorganization of the legal health insurance—I would say—after World War II will be initiated. We achieved a fair reconciliation of interests in Lahnstein. The basic objective that we have to make the health insurances weatherproof for the next century has not been abandoned. On the contrary, regarding a long-term stabilization of the system, we are achieving more now than in the original draft law. In the organization of the sick funds, the hospitals, and the balancing of the risk structures between the sick funds, a profounder structural reform than provided for by the first draft is scheduled now.

Ziller: That is to say, in the mid-nineties there will be a new discussion with the keywords of basic care or a division into normal and optional benefits?

Seehofer: I am saying quite openly that we need a third reform stage, so that all that can be upheld until far into the next century. So that nobody will say in two or three years: Seehofer's reform has also failed. Independently of what we are doing now and what, in my opinion, has turned out very well, we need this further stage. It must

answer the question about what will be secured in solidarity over the long term and what is one's own responsibility. However, this is not necessarily connected with the question of normal or optional benefits. One could also do the same that we are doing with artificial dentures now. There we eliminate medically dubious benefits as uneconomic. Expert are to tell us in a special report how we are to proceed.

**Ziller:** You agreed in Lahnstein that lists of drugs that can be prescribed will be compiled. Have the parties thus agreed on the positive lists that were demanded by the Social Democratic Party of Germany [SPD] and rejected by the coalition so far?

**Seehofer:** Now everyone can argue on whether something is a positive or negative list. I do not argue about terms. I want to provide information on contents. A list of drugs that can be prescribed was agreed upon and it goes on from the existing legal situation. We already have rules on uneconomic, inefficient, or therapeutically dubious drugs. They are to be taken together and put into a more convenient form. Now I can have a long argument on what I call the list. It is a negative list if I show the drugs that are to be eliminated. Or I can say that it is a positive list by pointing out the drugs that are left after the uneconomic drugs have been eliminated.

**Ziller:** The many millions that could be saved by means of such lists are not contained in the DM11.5 billion?

**Seehofer:** No. I do not estimate structural effects because nobody knows how comprehensive the list is and how the habits of the doctors regarding prescriptions will specifically develop. I do not want to make financial calculations on an unsafe ground.

**Ziller:** Thus, the DM11 billion are there next year. What does this mean for the contributions next year?

**Seehofer:** It is the objective of the reform to achieve stable contributions over the short term. This is achieved if expenses do not increase more than revenues. If we implement the reform, this objective will be achieved.

#### **German Researchers Making Progress on Malaria Vaccine**

92WS0747A Duesseldorf VDI NACHRICHTEN  
in German 3 Jul 92 p 17

[Article by D.P.A.: "Joint BMFT-Industry Project: Malaria Vaccine in Sight; Procedure Already Successful in Tests With Animals"]

[Text] Bonn, VDI-N, 3 Jul 92—The World Health Organization (WHO) estimates that there are annually about 105 million new cases worldwide of people becoming infected with malaria. The only way of protecting oneself against infection today consists of taking medications that kill the parasite. However, because of the serious side effects of this chemotherapy—particularly damage to the liver and the eyes—it can only be used for a short

time, not permanently. This is why researchers are trying to develop a vaccine that will afford permanent protection. In so doing, they have now made their first advances, the Ministry for Research and Technology (BMFT) recently reported.

A joint project of the Behring Works (Marburg), the Pasteur Institute (Paris), and the Max-Planck Institute for Biochemistry in Martinsried, promoted by the BMFT, is alleged to have successfully produced certain components of the malaria pathogen employing biotechnical methods and combined them in such a way that they were successful in tests conducted with animals. But, whether these results can be applied to humans is still an open question.

A big problem in developing a malaria vaccine lies in the fact that the pathogen—a unicellular parasite—goes through various stages in the human body, attacks different cells in the liver and in the blood, and repeatedly changes its points of attack on the immune system. A prerequisite to the production of a vaccine is therefore to first identify the effective antigens, that is, those structures of the parasite that trigger a defense reaction of the immune system in the human body. Some of these antigens have now been identified in the malaria pathogen's blood stage, according to the BMFT. Whether there are enough of these antigens in humans for a vaccine, however, is yet to be determined.

## **IRELAND**

#### **Quarantine of Imported Farm Animals To End**

92WE0668A Dublin IRISH INDEPENDENT  
in English 3 Aug 92 p 8

[Article by Willie Dillon, Agriculture Correspondent: "Disease' Row As Curb on Farm Animal Imports Goes"]

[Text] Quarantine restrictions on farm animals imported into Ireland are to be abolished this week as one of the most controversial aspects of the new EC open market comes into effect.

However, it will be at least another two years before Ireland's borders are opened up for the free movement of domestic pets between here and other Community countries.

From Thursday, the Department of Agriculture quarantine centre at Spike Island, Cork will no longer take in farm animals from other EC member states, as they can be imported here freely.

Opponents of opening up our borders to overseas animals strenuously argue Ireland runs a serious risk of allowing in foot-and-mouth disease which would destroy our present very high animal health status.

But the Department says that, instead of exposing ourselves to risk, controls in the other EC countries have now come up to our stringent standards.

Most importantly, the opening up of Community frontiers does not mean Ireland will lose its valuable place on the so-called "white list" of countries with the highest animal disease-free status.

Only two other EC countries are on the white list, membership of which clears them to sell meat products on major international markets such as the US and Canada.

It is understood American regulatory authorities have assured the Republic our exports will not be affected by removal of quarantine restrictions.

Ironically, the upgrading of disease controls in other EC states means they are now also potential white-listed countries—and could provide stiffer competition for Ireland on international markets.

Part of the demands made by the Government here in agreeing to removal of controls was that all other EC countries abandon their vaccination policy against foot-and-mouth and instead adopt our tougher slaughtering policy.

In reality, only a small number of breeding animals are imported into Ireland from the Continent each year, but such is the fear of foot-and-mouth disease that many farmers are still very unhappy with the opening up of our borders.

The ICMSA says it is not altogether reassured about the change and is still concerned about the implications for this country. It believes the case should still be made for turning Ireland into an EC "breeding sanctuary," producing disease-free stock.

The Spike Island quarantine centre will continue to operate and take in the small number of animals which come from non-EC countries, such as breeding cattle from Australia.

## UNITED KINGDOM

### Vaccines Withdrawn After Meningitis Develops

93WE0024A London THE DAILY TELEGRAPH  
in English 15 Sep 92 p 1

[Article by Peter Pallot]

[Text] Two of three brands of a vaccine routinely given to babies aged around 15 months were withdrawn by the Department of Health last night after some children developed meningitis.

The abrupt move, which will be announced to doctors later this week, follows fears that the two brands could lead to further cases of the brain disease.

Pharmacists swept batches of the MMR vaccine—measles, mumps and rubella (German measles)—from their shelves and were issued with emergency supplies of the third brand, which is considered safer.

The department said the change "was considered prudent following reports of meningitis in some children" who had received one of the two brands.

The vaccination programme, launched in October 1988, is regarded as a success because family doctors have protected 90 percent of children, leading to marked falls in levels of the three diseases.

It is the mumps element in the three-part vaccine which has given trouble, Dr. Kenneth Calman, Chief Medical Officer, said. It had given rise to mumps meningitis—a viral strain of the brain disease which can lead to neurological damage or death—in one in 11,000 children vaccinated. However, it is considered less serious than meningococcal meningitis.

Dr. Calman said the third, safer, brand of vaccine would in future be issued to all doctors ordering MMR doses.

There had been no confirmed cases of meningitis linked to the third vaccine, known as MMR II and made by the American multi-national Merck, Sharp and Dohme.

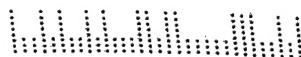
The brands associated with meningitis are made by Smith Kline Beecham and Merieux UK Ltd.

Dr. Calman emphasised that the benefits of vaccination overwhelmingly outweighed problems posed in a tiny number of cases in which side effects arose.

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